Emmie Vossen

UNCOVERING

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of the

A translation perspective on sickness absence practices in Dutch and Danish hospitals

Uncovering the microfoundations of the activation paradigm

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Colophon

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Uncovering the microfoundations of the activation paradigm

A translation perspective on sickness absence practices in Dutch and Danish hospitals

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Emma Elisabeth Maria Vossen
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Promotoren:

Prof. dr. N.M. van Gestel (Tilburg University)
Prof. dr. B.I.J.M. van der Heijden

Copromotor:

Prof. dr. E.A.J.A. Rouwette

Manuscriptcommissie:

Prof. dr. Y.W.M. Benschop
Prof. dr. J.-L. Denis (École Nationale d'Administration Publique, Montréal, Canada)
Prof. dr. P.L.M. Leisink (Universiteit Utrecht)
Prof. dr. J.H. Semeijn (Open Universiteit)
Dr. S. Boch Waldorff (Copenhagen Business School, Denemarken)

A journey of a thousand miles
begins with a single step

Lao Tse

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all directions

CHAPTER 1

General introduction

'It's really expensive for a hospital to have people on sick leave. And I think that if you don't take care of the people working for you, they get sick. I think my ten-year old daughter said it very well, she said, 'I don't understand that you go to work and then you get sick, why do you get sick at work?', I said, 'because I have so much to do', [and then she replied], 'well, that's stupid, that's really stupid, because who's going to take care of the sick?'. She is ten, and I think she said it all: Who is going to take care of the sick people?

[Employee DK2-4]

Of course, employees get sick for many different reasons, not only due to work pressures as in the above quote, but also for reasons unrelated to the work(place). Regardless of its cause, being absent from work due to sickness has significant social and economic consequences for sick-listed employees (e.g., social exclusion, loss of income) as well as for organizations (e.g., costs of replacement staff, lost productivity) (Van Gestel, Vossen, Oomens & Hollanders, 2013; Whitaker, 2001). Given these costs, my dissertation deals with an important question that flows from the one raised in the above quote: How do organizations – in my case, hospitals – manage the sickness absence of their employees, so that they can return to 'taking care of the sick people' in the hospitals? In particular, as I often had to clarify during my PhD trajectory, my main issue of interest was to understand how the sick-listed *employees* within hospitals (instead of the *patients*) are taken care of, in order for them to return to their work as soon as possible.

This issue has not been addressed in isolation. Rather, I have approached the study of sickness absence practices within organizations as the 'microfoundations' of the (inter)national 'activation paradigm' aimed to reduce the burden of sickness absence for society. Namely, although not mentioned by the employee in the above quote, sickness absence has major implications for the wider society as well (Whitaker, 2001). These implications include absence-related healthcare costs (around 10 billion euros per year in the Netherlands; Steenbeek, Hooftman, Geuskens & Wevers, 2010) and the costs of sickness benefits (16.8 billion Danish kroner, around 3.3 billion euros in Denmark, in 2013; Statistics Denmark, 2015a). Hence, the aim of my dissertation was to study how the activation paradigm is translated into sickness absence practices within hospitals in two different countries: the Netherlands and Denmark.

In this chapter, I will briefly introduce the concept of the activation paradigm. Next, I will elaborate on the theoretical approach of my dissertation, which is rooted in institutional theory and – more specifically – in Scandinavian institutionalism and the literature on translation. This elaboration also leads to the formulation of

the main research question of my dissertation. Subsequently, I will explain my choice for studying hospitals in the Netherlands and Denmark as the context of my research. Finally, I will give an overview of the research questions that are addressed in each of the subsequent chapters of my dissertation.

1.1 Setting the scene: The activation paradigm

Since the 1990s, many European countries have adopted the 'activation paradigm'[1] to curb the increasing costs of their welfare states (Bothfeld & Betzelt, 2011; Serrano Pascual, 2007; Weishaupt, 2011). The activation paradigm marks a normative shift in the task of the welfare state, from the traditional 'passive' provision of social benefits in case of an inability to work (due to unemployment, sickness or disability), to the 'active' prevention of benefit dependency through gainful employment and conditionality of benefit receipt (see Table 1.1 for an overview of this shift; Cox, 1998; Eichhorst, Kaufmann, Konle-Seidl & Reinhard, 2008). While the welfare state was previously seen as providing a safety net, nowadays it is argued that beneficiaries have become entrapped in this net and have to be propelled back into the labor market as soon as possible (Sol, Sichert, Van Lieshout & Koning, 2008). Work, or a higher employment level, is thereby considered as the key solution to improve the economic self-reliance of individuals on the micro level as well as to ensure the long-term viability of the welfare state on the macro level (Bonvin, 2008; Eichhorst et al., 2008; Weishaupt, 2011).

Table 1.1 Changes in the goal, task and underlying principle of the welfare state

	'Passive': Welfare provision	'Active': Provision of activation
Goal	Prevention of poverty through benefit provision	Prevention of benefit dependency through gainful employment
Task	Guaranteeing social rights (benefit receipt is seen as an entitlement)	Regulating individual's behavior (benefit receipt is conditional on rights and obligations)
Principle	Collective responsibility to protect individuals against social risk	Individual responsibility to be able to adapt to the requirements of an ever-changing economy

Source: *Based on Serrano Pascual (2007, pp. 15-23)*

1 In the literature, the 'activation paradigm' (e.g., MacEachen et al., 2007; Serrano Pascual, 2007; Weishaupt, 2011) goes by different names, such as the 'activation logic' (e.g., Bothfeld & Betzelt, 2011) or 'activation policies' (e.g., Bonvin, 2008). In my dissertation, I use these terms interchangeably.

In my dissertation, I focus on the activation paradigm in relation to sickness absence, or "absence from work that is attributed to sickness by the employee and accepted as such by the employer" (Whitaker, 2001, p. 420). More specifically, I focus on long-term sickness absence, which I define as absence from work for six weeks or longer (Dekkers-Sanchez, Hoving, Sluiter & Frings-Dresen, 2008). In this area, the activation paradigm promotes an early and sustainable return to work before employees have fully recovered, following a *hurt versus harm* rationale: "hurt – pain that is experienced during recovery – does not necessarily imply harm or an impediment to recovery" and hence, "pain [or hurt] is not a reason to stop all activities or to not return to work" (MacEachen, Ferrier, Kosny & Chambers, 2007, p. 43). Instead of focusing on the disabilities of sick-listed employees, the activation paradigm thus stresses uncovering their remaining ability to work, by considering adjustments of working hours and/or work tasks (Hetzler, 2009). The focus on workplace actions within the activation paradigm, together with the social and economic costs associated with sickness absence, have led to a greater involvement of organizations in the return-to-work process. Increased employer participation is also advocated by the Organization for Economic Co-operation and Development (OECD, 2010, 2015):

> *Employers are key players in the [sickness and] disability benefit system, even if they are not always recognized as such. Too often they are outside the policy process, being viewed as part of the problem, not part of the solution. In particular, sickness absence is a period during which much more could be done in most countries to monitor the health status of workers and manage their return to work (OECD, 2010, p. 14).*

Although by now the activation paradigm is regarded as a politically legitimate and appealing discourse (Bothfeld & Betzelt, 2011; Eichhorst et al., 2008; Weishaupt, 2011), so far, relatively little is known of how this paradigm is translated into actual sickness absence practices within organizations (e.g., OECD, 2010; Seing, MacEachen, Ekberg & Ståhl, 2014; Tjulin, MacEachen & Ekberg, 2010). This is remarkable, since the functioning of activation policies not only depends on an appropriate policy design, but also – and perhaps even more so – on the acceptance, translation and enactment of these policies by workplace actors (Eichhorst et al., 2008; Graziano & Winkler, 2012; Van Gestel & Nyberg, 2009). Moreover, effective implementation is dependent on the collaboration between multiple actors in sickness absence management (Hoefsmit, De Rijk & Houkes, 2013; Seing et al., 2014; Tiedtke et al., 2012). This is increasingly the case, since the number of workplace stakeholders has expanded as a result of the growing attention to sickness absence. Nowadays, these stakeholders may include supervisors, Human Resource (HR) managers, union representatives and healthcare providers (Franche, Baril, Shaw, Nicholas & Loisel,

2005). At the same time, the involvement of a multiplicity of stakeholders with various interests has been shown to create frictions (e.g., between line and HR managers) as to who is responsible for managing sickness absence (Cunningham, James & Dibben, 2004; Seing, Ståhl, Nordenfelt, Bülow & Ekberg, 2012; Van Gestel, Nyberg & Vossen, 2015). Conflicts over responsibilities may impair the return-to-work process when absence problems are left unaddressed or are dealt with (too) late or inconsistently. This may lead to a situation of "muddling through" in cases of sickness absence (C. Dunn & Wilkinson, 2002, p. 245), instead of an early return to work as espoused by the activation paradigm.

With regard to the link between activation policies and local sickness absence practices, the above underscores that "[a]s there is no one-to-one relationship between legislation and actual behavior, it is necessary to study the tension between policy and practice in its specific context" (Tiedtke et al., 2012, p. 242; see also Higgins, O'Halloran, & Porter, 2012). In my dissertation, I respond to this call by studying how sickness absence is managed in actual cases and within the context of the activation paradigm. Since there are considerable differences in the arrangement of the activation policies across countries (Eichhorst et al., 2008; Van Berkel, De Graaf & Sirovátka, 2012), I have taken a cross-national perspective in my dissertation by comparing the Netherlands and Denmark (more on this follows in section 1.3). Doing so enables me to study how activation policies are arranged in different welfare states (Daguerre, 2007) and whether these various arrangements lead to differences in how sickness absence is managed. My dissertation herewith aims to achieve a better understanding of the macro-micro linkages between the activation paradigm on the one hand and micro-level perceptions and actions of workplace stakeholders in sickness absence management on the other hand.

1.2 A Scandinavian institutionalist perspective on microfoundations

1.2.1 Institutional theory and institutional logics

The relationship between national activation policies and local sickness absence practices can be understood from the perspective of institutional theory, which seeks to explain how institutional demands – or society's expectations of appropriate behavior – affect the actions of organizations and individuals (Dacin, 1997; Scott, 2008). Institutional demands refer to the "rules and regulations, normative prescriptions and social expectations" exerted on organizations and individuals in a given field (Pache & Santos, 2010, p. 457). Also part of these demands are cultural templates called 'institutional logics': "the socially constructed, historical

patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 1999, p. 804). Institutional logics thus provide explicit and implicit rules of appropriate (inter)action and interpretation, and in so doing specify means and ends of behavior (Friedland & Alford, 1991; Thornton & Ocasio, 1999). As I will argue in Chapter 2, the activation paradigm can be considered an institutional logic, being a macro-level belief system regarding the division of responsibilities between the state and other stakeholders in social security, and including practices that define legitimate answers and solutions to deal with social issues of (in my case) sickness absence.

Nowadays, institutional theorists recognize that actors face multiple, often conflicting institutional logics (Greenwood, Raynard, Kodeih, Micelotta & Lounsbury, 2011; Kraatz & Block, 2008), and that this 'institutional complexity' is not a temporary situation but rather an enduring feature of many organizational fields (Greenwood et al., 2011). Furthermore, the broad and general nature of institutional logics (Friedland & Alford, 1991; Voronov, De Clercq & Hinings, 2013) as well as the occurrence of institutional complexity are assumed to provide organizations and individuals with opportunities for action, since they can use the multi-interpretability of, and contradictions between, institutional logics to their own advantage (Thornton, Ocasio & Lounsbury, 2012; Voronov et al., 2013). Accordingly, scholars have become interested in understanding the strategies and mechanisms of responding to (multiple) institutional logics, either on the level of organizations (e.g., Oliver, 1991; Pache & Santos, 2010) or on the individual level (e.g., Pache & Santos, 2013a; Reay et al., 2013). Hence, the institutional logics perspective acknowledges that micro-processes are "built from translations, analogies, combinations, and adaptations of more macro institutional logics" (Thornton et al., 2012, p. 4), rather than being mere lower-level, non-agentic copies of institutional logics.

Despite this increasing interest in knowing "how logics work in practice" (Lindberg, 2014, p. 486), to date, researchers are still catching up on their understanding of the so-called 'microfoundations' of institutional demands: the intra-organizational processes through which "macro-orders are 'pulled down,' and become imbricated in local or particular cases, situating macro-effects inside organizations and individuals" (Powell & Colyvas, 2008, p. 278; Thornton & Ocasio, 2008).[2] This research gap stems from the fact that institutional scholars have traditionally focused on the macro level of analysis instead of on the micro level, and paid more attention to the *outcomes* of institutional demands (e.g., homogeneity and stability) rather than to the *process*

2 Although I define the microfoundations of institutions as a top-down focus, Powell and Colyvas (2008) also defined a bottom-up approach, where micro-level actions aggregate to change or disrupt institutions. This approach is, for example, reflected in the concept of 'institutional work' (Lawrence & Suddaby, 2006).

through which organizations and individuals translate and enact these demands into practices (Powell & Colyvas, 2008; Suddaby, Elsbach, Greenwood, Meyer & Zilber, 2010). In addition, more recent efforts that aim to address this gap have been criticized for emphasizing the organizational over the individual level (for critiques see, e.g., McPherson & Sauder, 2013; Pache & Santos, 2013a; Reay et al., 2013), with researchers "looking for '*an* organization's' *single* response" to institutional demands, rather than for the responses of multiple individuals in the different subunits of an organization (Binder, 2007, p. 551; italics in original).

As a result, there is a limited understanding of the microfoundations of institutional demands, both in terms of taking a multi-level perspective and in relation to studying how (multiple) *individuals* interpret, translate and enact these demands in their local practices (after Felin, Foss & Ployhart, 2015). With this dissertation, I aim to contribute to a better insight into the microfoundations of an institutional logic (i.e. the activation paradigm), answering the following main research question:

> *What are the microfoundations of the activation paradigm in sickness absence management, within hospitals in the Netherlands and Denmark?*

I will address this question by applying and further developing a distinctive, process-oriented variant of institutional theory: 'Scandinavian institutionalism' (Czarniawska & Sevón, 1996, 2003) and its concept of 'translation' in particular (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996).

1.2.2 Scandinavian institutionalism and translation

Although Scandinavian institutionalism consists of different lines of inquiry (i.e. 'decoupling', 'sensemaking', and 'translation'; Boxenbaum & Strandgaard Pedersen, 2009), I focus on the concept of translation (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996), since it "offers both a conceptual and methodological way forward for researchers interested in moving beyond the totalizing view of institutions and institutional outcomes" (Lawrence & Suddaby, 2006, p. 243). Instead of viewing institutional demands as diffusing into organizations automatically and 'as is', the translation approach considers these demands (described in terms of 'ideas') as spreading and being transformed within organizations through translations by actors with specific interests (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996; based on Latour, 1986). In this way, translation can be defined as "the more or less deliberate transformation of practices and/or ideas that happens when various actors try to transfer and implement them" (Røvik, 2011, p. 642). The translation approach thus assumes that institutional demands are changed as they are translated: "to set something in a new place is to construct it anew" (Czarniawska & Sevón, 2005, p. 8).

In describing the translation process as the 'travels of ideas', Czarniawska and Joerges (1996) built on Latour's (1986) conceptualization of translation "in an attempt to understand a continuous circulation of management ideas and practices" (Czarniawska & Sevón, 2005, p. 8). The translation process is said to occur in four steps: idea, object, action and institution. In short, before an *idea* can be transferred to a new context, it first needs to be selected and framed as the rational solution to local problems, and support for its implementation has to be mobilized by aligning actors' interests. When chosen, the idea is turned into an abstract *object* that is disembedded from its old setting in terms of time and spatial features. Finally, the idea is re-embedded in the new context by translating it into practices, which are themselves at times materialized into *action*, and if repeated, may become stabilized into an *institution* (otherwise the idea remains a fashion). The translation process then restarts with the selection of a new idea (Czarniawska & Joerges, 1996; Sahlin & Wedlin, 2008). In my dissertation, I focus on the 'action' phase of the translation process, where the activation paradigm becomes re-embedded within organizational practices.

According to Sahlin-Andersson (1996), the translation process is guided by three implicit editing rules that are informed by the institutional environment. These rules are not available to actors as explicit "rules to follow", but only reveal as "rules which have been followed" when studying the translation process in hindsight (p. 85). In brief, rules of *context* help to make sense of ideas and re-embed them in a new context; rules of *formulation* enable phrasing an idea in a way that is appropriate to the new setting; and rules of *logic* describe logics of action (see also Helin & Sandström, 2010; Morris & Lancaster, 2006). Taken together, although the translation approach focuses on intra-organizational processes, as we saw in the previous paragraphs, it does so without losing sight of their institutional embeddedness (Boxenbaum & Strandgaard Pedersen, 2009; Czarniawska & Sevón, 2003). It therefore fits particularly well with my aim to study the microfoundations of the activation paradigm.

Nevertheless, in my dissertation, I do not only wish to *apply* the translation approach, but also to further *develop* the scholarly understanding of the translation process. To do so, I address two issues that have remained rather underexplored so far: (1) the translation work at an organization's frontline, and (2) the micro-level interactions occurring during translation. These issues are briefly explained below.

Translation work at the frontline

> *The perceived attributes of an idea, the perceived characteristics of a problem and the match between them are all created, negotiated or imposed during the collective translation process. All three are the results, not the antecedents of this process. [...] It is therefore the process of translation that should become our concern, not the properties of ideas (Czarniawska & Joerges, 1996, p. 25).*

As the above quote shows with regard to the translation approach, a distinguishing feature of Scandinavian institutionalism is its interest in intra-organizational processes as a response to institutional demands (Boxenbaum & Strandgaard Pedersen, 2009). Applied to translation, the focus is thus on the process of translat*ing* (as a verb) to understand why and how an idea is adopted in practice, rather than on the properties of an idea.[3] Put differently, the translation approach does not aim to study the intrinsic characteristics of an idea, but rather (the success of) its presentation during the translation process (Czarniawska & Joerges, 1996, p. 25).

Yet, until now, translation researchers have often stopped their investigations at the organizational level of analysis, studying the adoption of ideas by (top) managers but leaving aside how these ideas are subsequently translated at the frontline (Helin & Sandström, 2010; Reay et al., 2013; Teulier & Rouleau, 2013). This is remarkable, given that the acceptance of an idea at the organizational level is not necessarily followed by related changes in frontline practices (Reay et al., 2013; Zbaracki, 1998). Previous studies have thus left a gap in studying how institutional demands travel through organizations, resulting in a need to examine the actual "translation work" (Wæraas & Sataøen, 2014, p. 251) at an organization's frontline. The aim of Chapter 3 of my dissertation therefore is to further develop this understanding, where I will show how the activation paradigm is translated into organizational policies and frontline practices, by using Sahlin-Andersson's (1996) editing rules.

3 In this way, Scandinavian institutionalism is comparable to 'practice theory', which focuses on what people are actually ***doing*** ('praxis') in their everyday work, rather than solely studying their practices (Jarzabkowski, Matthiesen & Van de Ven, 2009). According to Czarniawska and Sevón (2003), Scandinavian institutionalism can even be seen as a precursor to practice theory: "Long before Pierre Bourdieu legitimized 'social practices' as an object of study, Nordic researchers studied 'praxis' ('practices' cannot be used in plural in Scandinavian languages)" (p. 13).

Micro-level interactions

> *[T]he spread in time and space of anything – claims, orders, artifacts, goods – is in the hands of people; each of these people may act in many different ways, letting the token drop, or modifying it, or deflecting it, or betraying it, or adding to it, or appropriating it. [...] When no one is there to take up the statement or the token then it simply stops (Latour, 1986, p. 267).*

As highlighted by the above quote, translators are vital for translation to occur, since they "energize an idea any time they translate it for their own or somebody else's use" (Czarniawska & Joerges, 1996, p. 23). What is more, translation is a *collective* process, as it is the result of the energy given to an idea by "everyone in the chain", with everybody shaping the idea according to his or her different interests as it moves from hand to hand (Latour, 1986, p. 267). Social interactions are thus central to the translation process (Johnson & Hagström, 2005; Mueller & Whittle, 2011).

Although key to the translation of ideas, the micro-level interactions occurring during translation have remained rather underexplored so far (Mueller & Whittle, 2011), with most scholars studying the translation process either from the perspective of one specific group of translators (e.g., Boxenbaum, 2006; Teulier & Rouleau, 2013) or from the angle of different translators but without consideration of their interactions (e.g., Nicolini, 2010; Waldorff, 2013). Addressing the "micro-interactional work" (Mueller & Whittle, 2011, p. 189) involved in the translation process is therefore central to Chapter 4 of my dissertation. To do so, I will combine the translation approach with social exchange theory (Blau, 1964), since this theory aims to understand workplace behavior by explicitly examining interpersonal interactions within organizations while seeing these interactions as guided by normative rules (Cropanzano & Mitchell, 2005; Di Domenico, Tracey & Haugh, 2009).

1.3 Research context

1.3.1 The Netherlands and Denmark (and Ireland)

Since it is unfortunately impossible to study all European countries in one dissertation, I initially included three countries in my study: the Netherlands, Denmark and Ireland. A first reason for choosing these countries is their similarity in terms of sickness absence rates and the resulting equal challenge to reduce the inflow into the sickness (and disability) benefit system (OECD, 2008). Together

with their reputation as 'employment miracles' regarding their approach to combat unemployment (Auer, 2002; Schwartz & Becker, 2005; Torfing, 1999), I expected that the three countries would have implemented the activation paradigm in their sickness absence policies as well. Another reason for selecting the Netherlands, Denmark and Ireland is the difference in the division of responsibilities between the government and employers in their national sickness absence policies: while the Dutch policies emphasize the (financial) efforts of employers in sickness absence management, the Irish policies stress the efforts of the central government. Denmark is in between these 'extremes', since local governments (municipalities) are mainly responsible but employers are increasingly given a role as well (OECD, 2008). These differences would enable me to study whether a different arrangement of the activation policies in terms of roles and responsibilities leads to variation in the management of sickness absence, which was the reason for taking a cross-national perspective.

However, having studied the national sickness absence policies of the three countries (see Chapter 2) led me to conclude that the activation paradigm is largely absent in the Irish policies. Hence, the OECD's (2008) conclusion regarding Ireland that "[c]ompared to most OECD countries, systems and structures in place are still quite traditional, passive and reactive" (p. 29) is still valid more than five years later, and the activation paradigm has not yet been picked up in the Irish sickness absence policies, despite efforts to do so. Although I still believe that the three-country comparison would provide interesting insights into different responses to growing European-level pressures for activation, this finding meant that Ireland no longer presented an appropriate case for studying the microfoundations of the activation paradigm. I therefore decided to drop Ireland from further research, and to focus on the Netherlands and Denmark.

1.3.2 The healthcare sector and hospitals

I explored the microfoundations of the activation paradigm in an industry where sickness absence presents a major challenge: the healthcare sector. First, on average, the healthcare sector faces higher sickness absence rates than other industries. In 2013, the sickness absence rate across the Netherlands and Denmark was 3.9 and 3.8 percent, respectively, against 4.8 and 6.1 percent in healthcare in the two countries (Statistics Netherlands, 2015a; Statistics Denmark, 2015b). These higher percentages have been ascribed to the greater physical and psychosocial workload, exposure to biological agents (i.e. bacteria and viruses), and to reorganizations within the healthcare sector (Michie & Williams, 2003; The Inspectorate SZW, 2013). Second, and most important in the long run, healthcare organizations are increasingly confronted with employee shortages (Buchan & Aiken, 2008). Estimates by

Table 1.2 Overview of hospitals included in this dissertation

	The Netherlands		Denmark
City Hospital (NL1)[a]	Private, non-profit hospital[b] ± 650 beds, ± 2,500 FTEs	**Medical Center (DK1)**	Public, non-profit hospital ± 650 beds, ± 5,500 FTEs
	2010: Revision of sickness absence policy by a consultancy firm; introduction of activation paradigm. Managers received training, but were supposed to educate the employees on their wards themselves		2007: Revision of sickness absence policy; idea and procedures reflect activation elements
	SA-rate[c] at time of study: ± 3.5%		SA-rate at time of study: ± 4.0%
Health Clinic (NL2)	Private, non-profit hospital ± 400 beds, ± 1,600 FTEs	**Region Hospital (DK2)**	Public, non-profit hospital ± 700 beds, ± 4,000 FTEs
	2010: Revision of sickness absence policy by a (different) consultancy firm; introduction of activation paradigm. All managers were trained and were assumed to educate their employees during employee meetings		2011: Revision of sickness absence policy by representatives of (HR) management and employees, due to pressures from the union for the equal treatment of employees; introduction of activation paradigm
	SA-rate at time of study: ± 3.5%		SA-rate at time of study: ± 4.5%

Notes: [a] *Names of the hospitals are pseudonyms;* [b] *The inclusion of private or public hospitals depends on the organization of hospitals in the two countries, but they are all non-profits (NVZ, 2010);* [c] *SA = sickness absence*

the European Commission predict a lack of 230,000 physicians and 590,000 nurses in the European Union by 2020 (Glinos, 2012). This problem is particularly pressing given the aging of the (working) population, which increases the demand for care but at the same time decreases the supply of healthcare personnel (Buchan & Aiken, 2008). More generally, examining the healthcare sector is socially relevant, since the costs of healthcare are the second highest public expenditures after those on social protection. In 2013, the Dutch and Danish government spent 36.7 and 44.0 percent on social expenditures, respectively, followed by 17.7 and 15.3 percent on healthcare (Statistics Netherlands, 2015b; Statistics Denmark, 2015c). These issues reveal the importance of managing sickness absence in the healthcare sector and, hence, make it a relevant research setting to study how the activation paradigm is given shape in practice.

More specifically, I conducted my research in hospitals, since these organizations are internationally comparable in terms of the kind of services delivered (i.e. patient care) and in their hybrid organizational structure of "hosting multiple professional

disciplines *and* balancing [governmental,] professional and commercial goals" (Greenwood et al., 2011, p. 355; italics in original; see also Thornton & Ocasio, 2008). What is more, hospitals are large enough to select sufficient cases of long-term sickness absence, and to study this thorny issue without violating the anonymity and privacy of individual participants. In addition, to avoid examining the peculiarities of a single organization (Bechky, 2011), two hospitals were selected in both the Netherlands and Denmark. Since my main issue of interest was to understand the translation of the *macro*-level activation paradigm into *micro*-level sickness absence practices, at the *meso* level I aimed for as much comparability of the hospitals as possible. Therefore, the hospitals were chosen for their similarity in type of organization (i.e. non-profits), capacity (i.e. amount of beds) and above-average hospital size in terms of full-time equivalents (FTEs) (around 1,400 and 2,000 FTEs in the Netherlands and Denmark, respectively; Danske Regioner, 2015; DHD, 2015). Although not part of the selection criteria, all four hospitals appear to have low sickness absence rates, compared to the sector average. Table 1.2 provides a brief overview of the four hospitals included in my dissertation.

1.4 Research questions and structure of the dissertation

Just as the 'travels of ideas' metaphor, I view my dissertation as a journey from the macro, via the meso, to the micro level of analysis. First, Chapter 2 starts off at the (inter)national level with a comparison of the activation paradigm in the Netherlands, Denmark and Ireland. Then, in Chapter 3, I travel from the macro level to the meso and micro level by exploring how the activation paradigm is translated into organizational policies and frontline practices of sickness absence within the four hospitals. In Chapters 4 and 5, I reside at the micro level (although always with an eye on higher levels of analysis), where I unpack how local dyads of managers and employees translate the activation paradigm into sickness absence practices in their interactions (Chapter 4), and whether and how experiences with returning to work differ between cases of physical and mental health complaints in the Netherlands and Denmark (Chapter 5). Finally, my journey comes to an end in Chapter 6, where I reconnect the three levels and discuss the findings of my research, in order to answer the main research question of my dissertation (see Section 1.2 and repeated here):

> *What are the microfoundations of the activation paradigm in sickness absence management, within hospitals in the Netherlands and Denmark?*

Chapter 2

Understanding how the activation paradigm is given shape in the sickness absence policies at the macro level in the Netherlands, Denmark and Ireland is essential luggage for travelling to the microfoundations. Developing this understanding is central to Chapter 2, "*The activation logic in national sickness absence policies: Comparing the Netherlands, Denmark and Ireland*". In this chapter, I approach the activation paradigm as an institutional logic that consists of underlying ideas about problems and solutions and an (often neglected) governance system that defines responsibilities, routines and regulative instruments for putting these ideas into practice. The research question is:

> *How is the activation logic understood and given shape in the national sickness absence policies in the Netherlands, Denmark and Ireland, in terms of underlying ideas and governance systems?*

I study this question by means of a multiple-case study design (Yin, 2009), with the Netherlands, Denmark and Ireland as my cases. Data stem from a literature review and 18 interviews across the three countries with government officials, representatives of employers' associations as well as unions, and with researchers. All the interviewees are experts in the field of sickness absence, return to work, employment and working conditions, or social security in general.

The chapter shows that while the Netherlands and Denmark have adopted the activation paradigm, Ireland has not (leading me to exclude this latter country from further study, as I have explained in Section 1.3). In addition, I demonstrate that although the underlying ideas of the activation paradigm in the Netherlands and Denmark are similar, its governance systems differ when looking at the roles and responsibilities of employers and the policy instruments used to trigger their behavior in sickness absence management. Theoretically, this chapter points to the importance of explicitly including governance systems in studying "institutional logics in action" (Lounsbury & Boxenbaum, 2013, p. 5).

Chapter 3

Carrying the information obtained in Chapter 2 in my suitcase, in Chapter 3, "*Translation in practice: Cherry-picking activation policies*", I study how the activation paradigm is translated into organizational sickness absence policies (meso level) and frontline practices (micro level) in the four hospitals across the Netherlands and Denmark. To do so, I use the translation approach and especially Sahlin-Andersson's (1996) editing rules (see Section 1.2). The research question guiding this chapter is as follows:

How are national activation policies re-contextualized, re-labeled and defined into actions within organizational policies of sickness absence, and in daily sickness absence practices at the frontline?

To address this question, I use a multiple-case embedded design (Yin, 2009), considering the hospitals as my cases and five to six 'networks of local actors' around long-term sickness absence within each hospital as the embedded units of analysis (21 networks in total). Data stem from the hospitals' sickness absence policies and from 61 semi-structured interviews with the most important workplace actors involved in the 21 local networks: sick-listed employees, their direct managers, and – depending on the country and the hospital – HR managers, union representatives, occupational health physicians, and other work and health professionals.

In brief, I show how the activation paradigm is implemented in the sickness absence policies and practices of the Dutch and Danish hospitals through what I refer to as 'selective coupling' or 'cherry-picking': translating only those components of the activation policies that primarily serve the hospitals' business interests and not necessarily those of sick-listed employees (compare returning to work 'as *soon* as possible' with 'as soon as *possible*', respectively). This chapter reveals how 'translation work' within organizations, and especially at the frontline, determines how an idea is finally given shape in actual organizational policies and practices. Each editing rule (context, formulation and logic) contributes in its own way to achieving a better understanding of how organizational actors merge the demands arising from the activation policies with existing pressures in daily operations.

Chapter 4

In Chapter 4, "*Quid pro quo: Understanding the role of social interactions in translation processes*", I arrive at the micro level. Here, I build a bridge between the translation approach and Blau's (1964) social exchange theory in 'a social exchange perspective on translation', in order to understand the micro-level interactions that occur in translating the activation paradigm. The research question addressed is:

What role do social interactions play in the translation of macro-ideas (such as the activation paradigm) into micro-level practices (like in sickness absence management)?

To answer this question, I specifically focus on the social interactions between local managers and their sick-listed employees, since they are the most important actors in the employment relationship. Methodologically, I consider these dyads as the cases, within the context of the four hospitals in the Netherlands and Denmark. Data consist of 42 semi-structured interviews with managers and their sick-listed employees.

In short, in this chapter, I nuance the findings of the previous chapter by showing how managers' translations of the activation paradigm as mainly serving the interests of the hospital or those of employees depend on their negative or positive perception of the social exchange with their sick-listed employees. As I will demonstrate, these perceptions are based on both past and present social exchanges. In doing so, this chapter highlights the important role of 'micro-interactional work' in the translation process. More specifically, it shows how this process is motivated by a 'norm of reciprocity', therewith further explaining *why* translation occurs.

Chapter 5

Still residing at the micro level, in Chapter 5, "*'Dis-able bodied' or 'dis-able minded': Stakeholders' return-to-work experiences compared between physical and mental health conditions*", I explore whether the return-to-work experiences of the various workplace actors involved in sickness absence management differ between cases of physical and mental health conditions, in both the Netherlands and Denmark. The reason to write this more practice-oriented chapter is that – by the end of my PhD trajectory – several researchers appeared to have studied return-to-work experiences, but did not explicitly address potential differences between physical and mental cases. However, during my research, I noticed how workplace actors frequently talked about different return-to-work experiences with different kinds of illnesses. The research questions guiding this chapter therefore are as follows:

> *How and why do the return-to-work experiences of various workplace stakeholders differ between physical and mental health conditions, and what are the consequences of potentially different experiences for the return-to-work process in both health conditions?*

As in Chapter 3, I examine these questions by means of a multiple-case embedded design (Yin, 2009), but here the two countries are my cases and the networks of local actors around physical and mental illnesses are the embedded units of analysis.[4] Data in this chapter stem from the 61 interviews with the workplace actors involved in the 21 local networks.

In brief, the chapter shows that while the activation paradigm does not distinguish between causes of absence, the workplace actors argue for a differential approach of physical and mental cases, with assessing work ability and following official return-to-work guidelines being perceived as more important in mental than in physical cases. However, I reveal the questionability of this distinction, since both mentally

4 However, to promote easy reading in this chapter, 'cases' refer to instances of sickness absence.

and physically sick-listed employees seem to benefit from an equal dialogue on work ability and the implementation of a return-to-work plan. Although not a theoretical chapter, in line with the translation approach, it does show how the original activation paradigm is changed when local actors add a (in their eyes, necessary) distinction between physical and mental causes of absence to it.

Chapter 6

Finally, in Chapter 6, my journey comes to an end with a general discussion. In this chapter, I reconnect the different levels of analysis studied in Chapters 2 to 5 to answer the main research question of my dissertation. Subsequently, I discuss the theoretical contributions of my dissertation for (Scandinavian) institutional theory and the literature on translation in particular, and the practical contributions for policy makers and businesses. I also reflect on the research design of my dissertation and provide suggestions for future research, and end with a short conclusion. In sum, my dissertation tells the journey of a travelling idea, showing how pit stops at different locations add to or change (parts of) an idea during its travels.


+
macro level

CHAPTER 2

The activation logic in national sickness absence policies: Comparing the Netherlands, Denmark and Ireland

This chapter is based on Vossen, E., & Van Gestel, N. (2015). The activation logic in national sickness absence policies: Comparing the Netherlands, Denmark and Ireland. European Journal of Industrial Relations, 21(2), 165-180. An earlier version of this chapter was presented as a paper at the 2013 International Labor and Employment Relations Association (ILERA) Conference, Amsterdam, the Netherlands, June 20-22, Track 4: 'New forms of regulation and governance'.

This chapter compares sickness absence policies in the Netherlands, Denmark and Ireland, examining whether and how the institutional logic of 'activation' that is paramount in Europe is understood and given shape in each country. They differ in their support for the underlying ideas of 'activation', and especially vary in the design of their governance systems, as can be seen in the allocation of responsibilities, the description of return-to-work routines and the use of regulative instruments. These findings contribute to institutional theory by demonstrating the important but often neglected role of national governance systems in the macro-micro linkage between institutional logics and organizational and individual behavior. Since sickness absence is a major cause of workforce inactivity, the practical relevance of this study is the comparative reflection of recent policy developments to improve sickness absence management.

2.1 Introduction

Since the 1990s the 'activation logic', which regards paid work as a better type of welfare than benefit receipt, has changed European welfare states from passive to active benefit systems (Eichhorst et al., 2008; Kluve et al., 2007; Serrano Pascual, 2004; Weishaupt, 2011). The essence of the activation logic is to increase labor market participation by facilitating access to employment and to inhibit exit from the labor market on unconditional benefit receipt. This should ultimately prevent dependency on social benefits, promote social inclusion and decrease public spending, so that the welfare state remains financially viable (Aust et al., 2012; Eichhorst et al., 2008).

Although the activation logic has been implemented widely, more attention is paid to unemployment and social assistance than to sickness absence (OECD, 2008), which can be defined as "absence from work that is attributed to sickness by the employee and accepted as such by the employer" (Whitaker, 2001, p. 420). The limited attention to sickness absence is remarkable, since it is a major cause of workforce inactivity (OECD, 2006) and has significant economic and social implications for the employee, the employer and the wider society (see Chapter 1; Whitaker, 2001). Moreover, sickness absence rates are expected to increase because of an aging workforce, unhealthy lifestyles and growing work pressure, which may result in greater risks of chronic diseases and psychosocial problems (Kirsten, 2008). Addressing sickness absence problems should thus have a high priority for national governments as well as for local actors, in particular for employers and employees.

Within the area of sickness absence, the activation logic stresses that work-related illness should be prevented and that employees with a reduced capacity for

work should be kept on the labor market (Høgelund, 2003). Rather than regarding sickness absence as "uncontrollable and, hence, not subject to [...] action" (Patton & Johns, 2012, p. 229), the underlying idea is that being sick does not (necessarily) mean that one cannot work and that continuing work while being ill may even have a positive influence on a full return to work (Roeters, 2005). Consequently, sickness absence policies should no longer stress an employee's inability to work, but his or her residual capacity for work (OECD, 2008). Along with a shift in underlying ideas, the activation logic also entails a new perspective on governance. Instead of governing sickness absence merely at the national level, with the government, employers' associations and trade unions in control, a devolution of governance to localities is promoted, for example to individual employers and employees or to municipalities (Etherington & Ingold, 2012; Jessop, 2002). Local actors are thus assumed to play an important role in preventing sickness absence from work and to ensure an early return to work (Eichhorst et al., 2008; Kluve et al., 2007).

The aim of this chapter is to compare sickness absence policies in the Netherlands, Denmark and Ireland, examining whether and how the activation logic is understood and given shape in each. We have selected these countries for two reasons. First, they have similar sickness absence rates and therefore share an equal challenge of reducing recourse to sickness benefits (OECD, 2008). Second, since these countries are said to have been particularly successful in activation when it comes to unemployment (Auer, 2002; Torfing, 1999), it seems likely that they have also taken up the activation logic in the area of sickness absence. Despite a similar challenge to reduce sickness absence rates, each country has its own history and traditions that may create distinctive responses. We therefore wish to explain both similarities and differences between the policies of these three countries.

This chapter is structured as follows. We start with a discussion of the theoretical background, grounded in the literature on institutional logics. We define the activation logic as an institutional logic and show how institutional logics consist of 'underlying ideas' and 'governance systems'. We then describe the methods of our study, and discuss whether and how the activation logic is understood and given shape in national sickness absence policies in terms of their underlying ideas and governance systems. Next, drawing on expert interviews, we attempt to understand similarities and differences in the adoption of the activation logic, and discuss the impact of the governance systems on the role of employers in each country. Finally, we discuss the implications of our study and develop suggestions for future research.

2.2 Institutional logics and the logic of activation

The logic of activation can be perceived as an institutional logic, since it involves a fundamental reorientation of the regulative, normative and cultural-cognitive elements of the welfare state (Greenwood, Díaz, Li & Lorente, 2010; Scott, 2008). Institutional logics can be defined as the "formal and informal rules of action, interaction and interpretation that guide and constrain decision makers" (Thornton & Ocasio, 1999, p. 804); they specify "the content and meaning of institutions" (Thornton & Ocasio, 2008, p. 100) by providing the means by which specified ends are to be achieved (Friedland & Alford, 1991, p. 251). Decision makers – whether at the individual, organizational or societal level – are assumed to comply with these rules in order to make sense of situations and thereby to behave appropriately and gain approval from important referents (Greenwood et al., 2011). Understanding the actions of decision-makers thus necessitates studying the institutional logics surrounding these actions.

Institutional logics refer not to specific laws or policies but to the *underlying ideas* (Greenwood et al., 2010), in particular about the specification of problems and the justification of solutions (Greenwood, Suddaby & Hinings, 2002). Underlying ideas may, for example, define "what kind of state intervention is appropriate [...] and which actors need to be organized" (Weishaupt, 2011, p. 63). Institutional logics are accompanied by *governance systems* (Rao, Monin & Durand, 2003; Thornton et al., 2012), which can be defined as the "institutional structures of authority transposing public law into action" (Weishaupt, 2011, p. 63). As such, they are regulatory and normative means which guide and control behavior, guarantee stability and maintain order; they involve a division of responsibilities, a description of routines and a choice for regulative instruments (Dacin, Goodstein & Scott, 2002; Scott, 2008; Scott, Ruef, Mendel & Caronna, 2000). Thus while underlying ideas provide a substantive framework for understanding problems and developing solutions, governance systems confine action to this framework.

While institutional theorists have paid ample attention to the underlying ideas of institutional logics, their focus on the accompanying governance systems has been limited (Dacin et al., 2002; Suddaby, Cooper & Greenwood, 2007). This is surprising, since the latter are a crucial factor in understanding "institutional logics in action" (Lounsbury & Boxenbaum, 2013, p. 5), as they attempt to influence and control behavior (Dacin et al., 2002, p. 51). In this chapter we aim to contribute to the current debate in institutional theory on the relationship between institutional logics and organizational and individual behavior, by examining the role of national governance systems in understanding this macro-micro linkage. By conducting a cross-national study, we examine the relationship between the underlying ideas and governance systems of an institutional logic: the activation logic.

2.3 Methods

We conducted case study research, since this helped us gain insight into the perspectives of multiple stakeholders on national sickness absence policies. We first performed a literature review, involving legal documents such as laws and policies, policy evaluations and scientific articles on the activation logic and its implementation in different fields. This enabled us to understand the state of the art of the Dutch, Danish and Irish national sickness absence policies. Between September 2012 and May 2013 we undertook 18 expert interviews in the three countries, seeking the experts' reflections on the underlying ideas of the sickness absence policies and whether and how the activation logic has changed the governance systems of these policies (see Appendix A for the interview guide). The interviews were conducted face-to-face (with one exception) and the respondents included a diversity of stakeholders in each country: government officials, representatives of employers' associations, union representatives and researchers; Table 2.1 provides an overview of the respondents by country. All were involved in constructing, implementing or researching policies in the area of sickness absence, return to work, employment and working conditions or social security in general. The interviews were semi-structured and took between 41 and 92 minutes, 72 minutes on average. They were recorded and transcribed verbatim, providing some 230 pages of transcripts.

Table 2.1 Overview of respondents

	NL	DK	IE
Government (G)[a]	2	-	2
Employers' associations (EA)[a]	2	1	1
Trade union (TU)[a]	1	1	1
Researchers (R)[a]	2	3	2
Total	7	5	6

Note: [a] *These abbreviations are used in the text to refer to interviews.*

We analyzed the data by means of the two-step process described by Eisenhardt (1989). In the first step we created detailed case study descriptions for each country, in which the perspectives of the various respondents were highlighted, including similarities and differences between views within one country. In the second step we conducted cross-case comparisons in order to reveal similarities and differences between the three countries. As noted above, we concentrated on the underlying ideas and governance systems of the national sickness absence policies. Regarding the underlying ideas, we focused on the perspective on the sickness

absence problems and the ideas about how and by whom sickness absence should be addressed. With regard to the governance systems, we looked at the allocation of responsibilities and their regulation in the national policies. We distinguished between the allocation of the financial responsibility to compensate for a sick-listed employees' loss of income, and the assignment of the responsibility and the description of routines regarding their return to work (Knegt & Westerveld, 2008). Regarding the regulation of responsibilities, we identified three policy instruments defined by Vedung (1998): *sticks* (regulations with or without sanctions), *carrots* (subsidies and taxes) and *sermons* (moral persuasion).

2.4 Sickness absence policies in the Netherlands, Denmark and Ireland

In this section we describe the national sickness absence policies in the three countries, first elaborating on their underlying ideas and subsequently outlining their various governance systems.

Underlying ideas

In the Netherlands, the exceptional rates of sickness absence and disability – around 7 and 15 percent, respectively (Cox, 1998; Van Gestel et al., 2013) – led prime minister Ruud Lubbers to declare in 1990 that "the Netherlands is sick"; it was necessary to change Dutch attitudes towards sickness absence (Høgelund, 2003). This initiated the reform of the national sickness absence policies: during the 1990s and 2000s a series of regulations was introduced that adopted the activation logic (Sol et al., 2008; Van Gestel et al., 2013). Consequently, the responsibilities for sickness absence were devolved to individual employers and employees. The underlying idea was that employers and employees are in the best place to prevent sickness absence from work and to ensure an early return to work, since they are closest to the workplace (Knegt & Westerveld, 2008). This idea also led to the belief that the risk of sickness absence no longer needed collective coverage and that employers could bear the costs (Yerkes, 2011). Moreover, the *Wet Verbetering Poortwachter* (Gatekeeper Improvement Act, 2002) and the *Wet Werk en Inkomen naar Arbeidsvermogen* (Work and Income According to Capacity Act, 2006) shifted the focus from employees' incapacity to their residual work capacity.

In Denmark, the activation logic was embraced in the 2000s, when political attention was drawn to the high sickness absence rate, between 6.6 and 7.5 percent in the period 2000-07 (Johansen, Bihrmann, Mikkelsen & Lynge, 2009). The Employment Ministry issued action plans and initiated campaigns with such

titles as 'This is What We are Doing about Sickness Absence', 'Sickness Absence: A Common Challenge' and 'Sick with the Job' (Beskæftigelsesministeriet, 2003, 2008, 2010) and amendments to the *Lov om Sygedagpenge* (Sickness Benefit Act, 2003, 2005, 2010), in order to change the focus from an employee's loss of ability to his or her ability to work, and to stress that being ill and having a job are not mutually exclusive. Along with this new view on sickness absence, the responsibilities were (further) devolved to municipalities and employers. The underlying idea was that municipalities can be more responsive towards local and individual situations, since they are able to bridge the gap between policies and problems (Jensen, 1999) of sickness absence. However, it is increasingly recognized that bringing down sickness absence is a shared responsibility and that employers (and employees) should be given responsibilities as well (Beskæftigelsesministeriet, 2008).

In Ireland, by contrast, with a short-term sickness absence rate of around 4 percent and around 1 percent for long-term sickness absence since 1996 (OECD, 2008), the activation logic has not yet been formally adopted in national policies. The emphasis on an employee's residual capacity for work is not present: "The original [...] premise that when you're sick you should be in bed [...] is still what drives our system" (EA). Receiving sickness benefit is seen as an entitlement, not conditional upon individual efforts to return to work. However, the government has lately undertaken initiatives towards implementing the activation logic, "waking up to the fact that [...] an awful lot of people are in that grey space between being fit for work and being unfit for work" (G1). For example, a Partial Capacity Benefit Scheme (2012) has been introduced, allowing employees who are ill for more than six months to work while receiving a partial sickness benefit. Moreover, the Department of Social Protection tried in 2012 to devolve part of the financial responsibility for sickness absence to employers, with the initiative for a statutory sick pay period of four weeks.

Governance systems

The three countries show important differences in their governance systems for sickness absence, summarized in Table 2.2. Below, we describe the differences in more detail.

The consensus in the Netherlands about devolving sickness absence issues to local actors led to the allocation of both financial and return-to-work responsibilities to employers (and employees) (Van Oorschot, 2006). The degree of responsibility for Dutch employers has become unique in Europe, and has been labeled 'going Dutch' in sickness absence policies (Knegt & Westerveld, 2008). The privatization of the *Ziektewet* (Sickness Benefit Act) has radically increased employers' responsibility to compensate (from day one) at least 70 percent of an employee's salary, from six

Table 2.2 Sickness absence policies in the Netherlands, Denmark and Ireland

	NL	DK	IE
Governance system	Decentralized: employers	Decentralized: municipalities and employers	Centralized: Department of Social Protection (DSP)
Financial responsibility	Employers pay at least 70% of salary for the first 2 years, no waiting period	Employers pay the first 30 days, municipalities until 1 year, no waiting period	DSP pays 1 or 2 years after a waiting period of 3 days
Return-to-work responsibilities and routines	Employers responsible; steps and timeframe are formulated within the Wet Verbetering Poortwachter	Municipalities mainly responsible; steps and timeframe for employers defined in the Lov om Sygedagpenge	No regulations for the return to work of sick-listed employees
Regulation of employers' responsibilities	Many sticks, with sanctions; strong carrots; few sermons	Sticks, no sanctions; few carrots; many sermons	No sticks; some carrots; few sermons

weeks in 1994 to one year in 1996 and two years in 2004 (*Wet Verlenging Loondoorbetalingsverplichting bij Ziekte, VLZ)* (Yerkes, 2011). Furthermore, a detailed legal procedure laid down in the *Wet Verbetering Poortwachter* has made employers responsible for return to work, either in their own organization ('first-tier return to work') or in another ('second-tier return to work'). Moreover, according to the WIA, employers are obliged to take care of the return to work of employees with a remaining work capacity of more than 65 percent after two years of sickness absence (OECD, 2008). Employers who fail to comply are sanctioned, for example by having to pay an employee's salary for an additional year or the benefit costs of partially disabled workers for a maximum of ten years.

While Dutch employers thus bear full responsibility for sickness absence for two years, the legal framework directs their behavior. This combination of local responsibilities and state action is described as 'managed liberalization': "On the one hand, the role of the market in the system of social security is increased, but on the other hand, the state tries to manage this market and so it limits the freedom of choice" (Van der Veen & Trommel, 1999, p. 297). The regulation of Dutch employers is described as a carrot-and-stick-approach (Cox, 1998; Van Oorschot & Abrahamson, 2003). The sticks comprise the laws mentioned above, supported by sanctions, while the carrots are financial incentives taking the form of differentiated premia paid by employers for the sickness and disability benefit schemes (*Wet Modernisering Ziektewet*, Act on Modernizing the Sickness Benefit Act, 2013; *Wet Financiering Sociale Verzekeringen*, Act on Financing Social Security, 2004). Despite devolution to local actors, we thus see that government is as much in control as before the decentralization (Knegt & Westerveld, 2008).

Although municipalities *(Kommuner)* in Denmark have been financially responsible for sick-listed employees since 1973 (nowadays up to one year of sickness absence), the implementation of the activation logic led to a full devolution of responsibilities when they also became responsible for the return to work in 2003 (Johansen et al., 2008). This leaves few legal responsibilities for employers (Aust et al., 2012), which fits with the Danish flexicurity system: a high level of flexibility for the employer to hire and fire combined with strong social security for citizens (Johansen et al., 2008). However, with the implementation of the activation logic, some responsibilities for sickness absence were simultaneously devolved to employers (and employees). Employers are required to pay for 30 days from the first day of sickness absence since 2010 (often extended through collective agreements). This entails an increase from 15 days in 1993 and 21 days in 2008 (Arbejdsmarkedsstyrelsen, 2011; Johansen et al., 2008). Moreover, employers are given more responsibilities for facilitating the return to work, such as having an interview with the employee within four weeks of sickness absence, making a joint certification of the functional (in)capacities of the employee, and producing a return-to-work plan on the employee's request, if the employee is unable to return to work within eight weeks (Arbejdsmarkedsstyrelsen, 2011).

The Danish approach to regulating employers' behavior relies on the sticks within the *Lov om Sygedagpenge*, but without sanctions, backed up with sermons such as the campaigns and national action plans described earlier. This manner of regulating characterizes the 'Danish model' (Etherington & Ingold, 2012), in which there are "few legal instruments targeted at the labor market and much more is left to agreement between the social partners" (R3). This approach should lead to voluntary initiatives, related to the discourse of social responsibility in Denmark (Rosdahl, 2002). However, it is also used as a way for employers to legitimize their actions: "It's more easy for an employer to explain why he thinks it's a good thing to have this [sickness absence] conversation when it's written in the law" (EA). Finally, there are some carrots to help employers retain sick-listed employees; for example, a partial recovery scheme (*delvis raskmeldinger*, phased return to work) and a partial sickness absence scheme (*delvis sygemelding*, partial sick leave).

In contrast to the Dutch and Danish cases, responsibilities within the Irish sickness absence policies are centralized at the level of the national government, resting (mainly) with the Department of Social Protection. It administers income support during sickness absence for one or two years (depending on social insurance contributions), after a waiting period of three days (OECD, 2008). There are no legal responsibilities for employers to compensate a sick-listed employee's loss of income, nor are they obliged to provide return-to-work measures (OECD, 2008; Wynne & McAnaney, 2004). Their only obligation is to provide the employee with a written statement of the terms and conditions relating to sickness absence, for example,

wage payment, within two months of the start of employment (Conroy, n.d.). As a government representative explained, "in a way it comes down to the [...] personal attitude of the employer and the culture [of] the organization" (G1). Employers often do top up the sickness benefit to the employee's full salary (OECD, 2008), record absence and conduct return-to-work interviews (IBEC, 2011). Moreover, there are some voluntary initiatives to set guidelines on how to manage sickness absence and return to work, for example the Workplace Safety Initiative by the social partners in 2004 (Conroy, n.d.) and the work of the National Disability Authority (NDA, n.d.).

The Irish approach towards regulating employers' behavior consists (solely) of carrots (McGuinness, O'Connell, Kelly & Walsh, 2011; Murphy, 2009), since there are many subsidy schemes available to employers, such as the Employment Support and Wage Subsidy Schemes. However, these schemes focus on hiring the unemployed or inactive disabled rather than retaining sick-listed employees, or only target employees who are ill for more than six months, like the Partial Capacity Benefit Scheme. Moreover, some subsidy schemes are difficult to access or are infrequently used (IBEC, 2012; Wynne & McAnaney, 2004).

In sum, our study reveals how sickness absence policies in the Netherlands, Denmark and Ireland involve different governance systems. The Netherlands devolves responsibilities to employers, with public law binding their actions. Denmark, with its "munipalization of employment policy" (Etherington & Ingold, 2012, p. 37), makes municipalities mainly responsible (and employers to an increasing extent) for governing sickness absence, although bound by the *Lov om Sygedagpenge*. In Ireland, the national government retains sole responsibility for the governance of sickness absence. This implies that the devolution of governance inherent in the activation logic has only occurred in the Netherlands and Denmark, but with respect to different local actors: employers and municipalities.

2.5 Similarities and differences

By drawing from our expert interviews, we compare the underlying ideas of the Dutch, Danish and Irish sickness absence policies to understand similarities and differences in the implementation of the activation logic. Subsequently, we compare and discuss the impact of the governance systems on the role of employers in the three countries.

Underlying ideas: Understanding similarities and differences in the implementation of the activation logic

To quote a Danish respondent, "it's very clear that in the last decade the pendulum in all European countries has swung from accepting passivity towards putting much more efforts in activation" (R3). Whereas this has also been acknowledged in the literature on activation (Kluve et al., 2007; Weishaupt, 2011), our study shows that this is far less true for sickness absence policies in Ireland than in the Netherlands and Denmark. In the latter two countries the activation logic in the area of sickness absence shows a shifting focus from work inabilities to remaining work capacity, a devolution of responsibilities to localities (employers or municipalities), and the (increasing) recognition that solving sickness absence problems is a matter between the employee and his or her employer.

In contrast, the Irish sickness absence policies are said to reside in a 'policy paralysis' regarding the implementation of the activation logic (Murphy, 2009). According to the Irish experts, the underlying ideas of the activation logic are not implemented within sickness absence policies. This means that there is no national strategy for activation that guides local actions. As an Irish researcher expressed it, "the discussion is basically confirming that in the absence of an activation strategy the changes shouldn't happen, because really, we don't know what we are doing and we don't know why we are doing it" (R1). The employers' representative confirms this interpretation: "Our system hasn't caught up with that it's actually good to be at work and you're better off [...] staying active and coming back part-time" (EA).

Despite this situation, there does seem to be support for the activation logic in Ireland, in particular from the government and from IBEC, the employers' confederation. For example, employers would agree with a more structured return-to-work process that focuses on an employee's capacities for work (IBEC, 2012). If other actors also start to recognize the activation logic as a convincing format to solve the problem of sickness absence, it might be just a matter of time before this support will affect the national policies. On the other hand, our study shows that it is not certain whether enough support will be mobilized soon. For instance, the union representative argues that they would oppose the paradigm if it means "more blame being put on the worker" and if employees would return to work without having "a career progression in front of them" (TU). One government representative adds to this that employees see activation measures as "an attack on social insurance rights" but also argues that chances are small, given the current economic recession, that "developmental, positive measures are going to be welcomed" by employers (G1). In addition, the two researchers are not optimistic, since earlier initiatives have failed as well, as with 'The Developmental Welfare State' proposals (Murphy, 2009).

Apparently, creating a shared understanding of the sickness absence problem and justifying the activation logic as the solution for this problem is a prerequisite for change, since it generates the legitimacy needed for implementation and finally for institutionalization (Greenwood et al., 2002). This seems to have occurred in the Netherlands (framing the sickness absence problem as a national problem) and in Denmark (framing it as a shared challenge) (see also Cox, 2001), but the Irish government struggles at this point: "It's hard to articulate a vision that sort of says it's not just about reducing expenditures, we're trying to do something positive here as well" (G1). This may be due to the framing of the problem and the language that is used. For example, while in the Netherlands and Denmark the concept of 'rights and obligations' is used to argue for the conditionality of sickness benefits (Van Oorschot & Abrahamson, 2003), Ireland still speaks of entitlements: "We don't tend to word things that way. If you look at some of the [government] websites, what is written on top is 'entitlement'. That's a very different way of saying things" (G2). With a clientelistic political system, politicians are less inclined to "do things that would upset the voter" (R1) and thus to use harsher language.

Another explanation for the differences between the countries may be the urgency of the problem: whereas sickness absence (and disability) has historically been the most salient problem for the welfare state in the Netherlands and, albeit in a more gradual development, in Denmark (Høgelund, 2003), for Ireland unemployment has been an "easy option" (R1), a "quicker win" (EA), or at least a more urgent issue (Murphy, 2009) compared to sickness absence. The unemployment rate was almost 14 percent in 1990, and although it decreased to around four percent in 2000, it has risen again to 13 percent in 2013 (Eurostat, 2016). Nevertheless, the growing number of sickness beneficiaries, over 80,000 recipients in 2010, compared to around 55,000 in 2002 (Central Statistics Office, 2013; OECD, 2008) and the deficit in the sickness benefit fund may lead to a shared sense of urgency in the future: "Now this fund is in deficit, [...] it is actually getting a bit of attention" (EA).

Governance systems and the role of employers

The strengthened role for employers in sickness absence management, as occurring in the Netherlands and increasingly also in Denmark, implies an extension of the employment contract, since it is no longer solely defined as an agreement in which the employee agrees to perform work and the employer in return offers work and pay. It now also includes an agreement whereby the employer provides for return-to-work services and (temporarily) adjusted work, even if the employee is not able to carry out the agreed tasks. Employers thus now (are obliged to) take up part of the traditional function of the welfare state, as the employment contract is "being mobilized for public purposes" (Knegt & Westerveld, 2008, p. 100).

The role of employers is, however, disputed in all three countries. Discussion in the Netherlands revolves around the question whether employers' responsibilities have gone too far, especially in comparison to other countries. For instance, the degree of responsibility is particularly problematic for small and medium enterprises, since these "employers are incentivized but don't have the measures to act upon that" (EA2). They lack the necessary finances, knowledge and possibilities for return to work (Van Gestel et al., 2013). Nevertheless, according to the FNV (*Federatie Nederlandse Vakbeweging*), the main Dutch union confederation, the activation logic has been interpreted by Dutch employers as "an unbridled shifting [of responsibilities] to employees" (Van den Boom, Konijnenberg & Lotterman, 2013, p. 4). This coincides with the discussion in Denmark, which is about whether employers' responsibilities are sufficient. For example, while our union representative argues that employers "are only focusing on the employees and their responsibility to go back to work, and don't focus on working conditions and occupational health, and bringing down safety risks" (TU), the employers' representative comments that "if our costs are heightened even more [...], more companies are forced to fire their employees, because simply it's going to cost too much to keep them" (EA). This is supposed to counteract the aims of the activation logic.

Finally, and in contrast to both the Dutch and Danish cases, the debate in Ireland concerns who should be responsible for sickness absence, with the main actors (national government, employers and employees) pointing fingers to each other. For example, the employers' representative argues that the national government should create return-to-work possibilities, because "the phased return [...] essentially isn't supported by the illness benefit system" and that employees should take their responsibilities in returning to work, since "they don't always see work as part of the rehabilitation" (EA). At the same time, the union representative insists that "we would like to see more responsibilities on employers to have in place measures that allow [...] a phased return to work or [...] to change the way work is organized"; the government should take a more active role in this, since "when it's not in the law, employers won't do it" (TU). Finally, according to one of the government representatives, "it would've been a positive thing to have some kind of a statutory scheme where employers are required to engage more actively" (G1). The problem seems that nobody wants to take the responsibility, as that would involve bearing the costs (a wage payment period for employers or fewer entitlements for employees).

2.6 Conclusion and discussion

The aim of this chapter has been to compare whether and how the activation logic is understood and given shape in sickness absence policies in the Netherlands, Denmark and Ireland. In our qualitative comparative study we found large variation between the three countries, despite a common challenge to address sickness absence problems. The underlying ideas of the activation logic are only supported in the national sickness absence policies in the Netherlands and Denmark, while Ireland has not (yet) implemented these ideas as a solution to its problems. In addition, the national governance systems regarding sickness absence display considerable variation in the division and regulation of responsibilities. While these rest with the national government in Ireland, in Denmark they are devolved to municipalities and (increasingly) to employers, and in the Netherlands most are put on employers. The three countries also use different instruments in regulating these responsibilities: while the Netherlands draws on 'must rules' (Van Raak, De Rijk & Morsa, 2005) and sanctions, Denmark employs softer 'may rules' and Ireland has not implemented any regulations so far.

These findings may question the existence of a single activation logic. Earlier studies, such as the journal issue edited by Barbier and Ludwig-Mayerhofer (2004), already pointed to a large variation in the meaning and content of activation policies in Europe. Our study adds to this conclusion from the less researched area of sickness absence. However, we support Serrano Pascual's (2004) argument to distinguish between ideology and implementation. Our study demonstrates that the ideology of the activation logic tends to converge between countries (once adopted, as in the Netherlands and Denmark), while the implementation remains different, for example in terms of regulative instruments (sticks, carrots, sermons) and a distinctive division of tasks between government, social partners, individual employers and employees (governance system). Variation in the activation logic thus seems to concentrate on the level of governance systems, which confirms the importance of (national) governance systems in studies on activation.

Theoretically, our findings imply that an institutional logic is not necessarily aligned to one particular governance system, as is often (implicitly) assumed in institutional theory (Scott et al., 2000). The underlying ideas of an institutional logic can be associated with various governance systems, and these may convey *different* organizing principles to guide behavior of organizations and individuals. Our study thus highlights the important role of national governance systems as 'mediators in the process of logic implementation' or 'institutional logics in action' (Greenwood et al., 2010; Lounsbury & Boxenbaum, 2013). Given the variety in national governance systems related to a specific institutional logic, a similar set of underlying ideas may thus create a diverse impact on the behavior of organizations and individuals.

Addressing this variety and its consequences would deepen our understanding of the macro-micro linkage between institutional logics and organizational and individual behavior (Thornton et al., 2012).

Our study points to several interesting avenues for future research. One approach might be to examine more closely the relationships between the national government, employers' associations and unions in studying the sickness absence policies in the three countries. In particular, the role of the social partners in constructing these policies seems relevant in explaining national differences. According to our data they seem to have greater influence on the national sickness absence policies in Denmark and Ireland than in the Netherlands. This may allow them to resist a devolution of responsibilities from the national level to organizations and individuals. In the Dutch case, the government has developed considerable autonomy in sickness absence policies since the mid-1990s, as a political consequence of the disability crisis (Cox, 2001; Knegt & Westerveld, 2008; Van Oorschot & Abrahamson, 2003). By setting aside the social partners (Høgelund, 2003), the national government created the opportunity to install a dominant role in sickness absence policies for individual employers – albeit under legally defined conditions. Conversely, in countries (such as Denmark and Ireland) where the role of the social partners in labor market and social security issues is more influential, the government is less able to devolve responsibilities to the level of organizations and individuals.

Another interesting avenue for future research relates to the debate on historical convergence and divergence (Beckert, 2010; Serrano Pascual, 2004). Considering the sequence in which the activation logic is implemented in the sickness absence policies in the three countries (the Netherlands in the 1990s, Denmark in the 2000s and Ireland not yet), it can be hypothesized that it is only a matter of time before Denmark and Ireland will adopt a similar system to the Netherlands. This might especially be expected since the Netherlands has come to be seen as a successful frontrunner in implementing the activation logic (Sol et al., 2008). However, it is far from certain whether the Dutch example will become a template for other countries, since we found reluctance among Danish and Irish experts towards the Dutch system, especially towards the huge responsibilities for employers and a (supposedly) small role for the government. From this perspective a situation of persistent difference is more likely. This shows the need for comparative research on these policy developments with a longitudinal perspective. Related to this, we call for studies that aim to explain why the activation logic is implemented in one sub-field of social policy and not (or less) elsewhere. Generally, the field of sickness absence policies has received less attention in the implementation of the activation logic, as contrasted to employment policy (OECD, 2008). This issue may however be different for various countries, since our data revealed how it is related to national political deals in reforming the welfare state (Høgelund, 2003; Murphy, 2009).

Finally, an important issue for a future research agenda is whether the different roles assigned to actors in national policies will lead to different local actions. In the case of sickness absence management it can be expected that Dutch employers, having more incentives for actions in managing sickness absence than their counterparts in Denmark and Ireland, consequently put more effort into preventing health problems at work and retaining sick-listed employees. However, employers in Denmark or Ireland are probably motivated by incentives other than regulations and sanctions, and it would be theoretically as well as empirically relevant to compare the outcomes of different modes of governance. Studying the role of employers in sickness absence management, and the use of different regulatory instruments (sticks, carrots or sermons), may thus shed light on the actual importance of national governance systems for daily practices within organizations.


+
macro level
meso level
micro level

CHAPTER 3

Translation in practice: Cherry-picking activation policies

An earlier version of this chapter was presented as a paper at the 2014 European Network for Social Policy Analysis (ESPAnet) Conference in Oslo, Norway, September 4-6, in track 9a: 'Work and Welfare: the role of employers' as: Vossen, E., Van Gestel, N., Rouwette, E.A.J.A., & Van der Heijden, B.I.J.M. (2014). Translating activation policies in the Netherlands and Denmark: The role of employers in sickness absence management.

Building on the concept of translation and the editing rules in Scandinavian institutionalism, this chapter examines how national policies for 'activation' in sickness absence management are translated into organizational policies and frontline practices in four hospitals across the Netherlands and Denmark. Based on documents and 61 interviews with multiple frontline actors, our findings reveal 'cherry-picking' as a strategy to selectively translate national policies into daily practices in a manner that primarily serves organizational interests. Although each editing rule contributes in its own way, we show that especially their interconnectedness across levels adds to understanding the translation process. These findings highlight the importance for translation studies to take a multi-level approach that incorporates the sayings and doings of multiple interacting actors.

3.1 Introduction

Sickness absence, or absence from work that is ascribed to sickness (Whitaker, 2001, p. 420), is associated with high economic and social costs for employees, employers and for society in general. Recognition of these costs has made the prevention and reduction of sickness absence a top priority for countries across Europe (Johansen et al., 2009; OECD, 2010). Consequently, many European governments have adopted 'activation policies' in their sickness benefit systems during the past two decades (OECD, 2010).

Activation policies stress the promotion of an early and sustainable return to work of sick-listed employees (Hetzler, 2009), in order to advance individuals' welfare by enhancing social inclusion as well as to reduce the costs of the welfare state by securing labor supply (OECD, 2010). To achieve these dual goals, the focus in sickness benefit systems has shifted from determining the impairments of sick-listed employees, to "identifying that part of the individual's total capacity for work that can still be used", for example by adjusting the work(place) or the working hours (Hetzler, 2009, p. 376). This implies that being sick no longer equals the inability to work and thus the need to obtain a sickness benefit.

A significant change in this context is the devolution of (part of) the financial and return-to-work responsibilities regarding sickness absence from national governments to organizations, based on the assumption that the latter "are in a good position to judge what work their employees can still do and what work or workplace adjustments might be needed to accommodate the health problem that has arisen" (OECD, 2010, p. 14). Organizations, either public or private, are thus urged to (partly) take over former national public duties (Knegt & Westerveld, 2008). However, to

date, little is known about how the activation policies are actually implemented in the daily management of sickness absence within organizations (e.g., Nyberg, 2012; OECD, 2010; Seing, MacEachen, Ståhl & Ekberg, 2015; Tjulin, MacEachen & Ekberg, 2011). This is remarkable, given that the functioning of activation policies not only depends on an appropriate policy design, but also on the acceptance of these policies in the organizations responsible for implementing them (Eichhorst et al., 2008).

In this chapter, we aim to unpack how national activation policies are translated into the actual management of sickness absence within organizations. We do so in the specific setting of four non-profit hospitals across the Netherlands and Denmark, since an international comparison of similar phenomena in different contexts adds to obtaining generalizable insights into the translation process (McDermott, Fitzgerald & Buchanan, 2013, p. S94). In our study, we examine both the hospitals' sickness absence policies and the daily practices of sickness absence in networks of local actors. These networks include multiple actors involved in sickness absence management, for example, sick-listed employees, line managers and – where relevant – HR managers, union representatives, occupational health physicians, and other work and health professionals. So far, most research on the translation of activation policies has focused on a subset of these actors (for rare exceptions, see Nyberg, 2012; Seing et al., 2015; Tjulin, MacEachen & Ekberg, 2011), which does not allow for a multi-angle view on the translation of these national policies in day-to-day practices of sickness absence. This lack of attention to multiple actors is surprising, since effective implementation of these policies depends on the collaboration between multiple stakeholders in sickness absence management (Tiedtke et al., 2012).

Our theoretical framework is based on the concept of translation, or "the more or less deliberate transformation of practices and/or ideas that happens when various actors try to transfer and implement them" (Røvik, 2011, p. 642), and therefore fits particularly well with our research aim. We perceive translation as an editing process in which actors, as editors, are guided by certain editing rules that influence how new ideas are re-contextualized, re-labeled and defined into actions (Sahlin-Andersson, 1996). Our paper contributes to the scholarly literature on translation in three ways. By examining both the process and outcome of translation, we first show how "the editing rules are performed in practice" (Teulier & Rouleau, 2013, p. 309) on both the organizational and the frontline level. In so doing, our research highlights the interconnectedness of these editing rules, and points to the importance of taking a multi-level approach in translation studies. Second, we reveal how frontline actors couple national activation policies to their sickness absence practices by means of 'cherry-picking'. This response allows actors to implement national policies, yet in a manner that promotes organizational business interests rather than intended policy aims. Finally, by studying networks of local

actors instead of a single super- or subordinate actor, our study highlights how the translation process resembles a 'battlefield', where different actors with different interests vie for supremacy (Johnson & Hagström, 2005, p. 383). We show how the interests of some actors (in our case, those representing 'the employer') are often met at the expense of those of others (employees).

The structure of this chapter is as follows. We begin by explaining translation as our theoretical framework, which is followed by an explication of the activation policies in the Netherlands and Denmark. Subsequently, we elaborate on the methods of our study. Then, we show how the activation policies are translated into sickness absence policies (organizational level) and practices (frontline level). Finally, we discuss our research findings and their implications for the literature on translation.

3.2 The translation framework

The spread of ideas (or policies, practices) has traditionally been studied as a process of diffusion, in which ideas are treated as "'out there' and as adopted more or less 'as is'" (Greenwood, Oliver, Sahlin & Suddaby, 2008, p. 17; Sahlin-Andersson, 1996). In this approach, actors are seen as passive adopters, who conform to new ideas to gain legitimacy and in so doing install rather homogeneous practices (Sahlin & Wedlin, 2008). Consequently, diffusion studies remain rather silent on the process by which new ideas "wind their way through organizations" and become adapted to fit the local context (Ansari, Fiss & Zajac, 2010, p. 67; Reay et al., 2013). Examining idea spreading as a process of 'translation' – as in Scandinavian institutionalism – has gained increasing attention to address this research gap, since the translation approach focuses on how actors within organizations actively interpret and enact ideas in their daily practices (Boxenbaum & Strandgaard Pedersen, 2009; Czarniawska & Sevón, 1996).

Translation occurs when "T, a translator, transforms A – the source to be translated – into B – the target of the translation – in a local context" (Teulier & Rouleau, 2013, p. 312). This process consecutively involves selecting an idea, disembedding it from the old setting in terms of time and spatial features, and re-embeddeding it in a new context by translating the idea into practices. These practices are then at times materialized into action, and if repeated, they may become institutionalized (Czarniawska & Joerges, 1996). The translation process is said to follow three implicit editing rules, informed by the institutional environment (Sahlin & Wedlin, 2008; Sahlin-Andersson, 1996). Rules of *context* help to disembed policies from their original context and to re-contextualize them in a new setting, enabling actors to make sense of and embed new ideas in their local context. Editing rules of *formulation* entail the re-labeling of ideas in a manner that is appropriate to the new setting, so that ideas

are described in a different, yet recognizable way. Finally, rules of *logic* clarify the rationale or plot behind ideas, and describe "'how-to' recipes" or logics of action (Morris & Lancaster, 2006, p. 218; Helin & Sandström, 2010; Sahlin-Andersson, 1996). In our study, we build on recent literature that applied these editing rules (e.g., Helin & Sandström, 2010; Morris & Lancaster, 2006) to examine how "translation is done in practice" (Teulier & Rouleau, 2013, p. 314), a topic to which we turn now.

Exploring translation work at the frontline

Although an interest in intra-organizational processes is what distinguishes the translation approach from diffusion studies (Boxenbaum & Strandgaard Pedersen, 2009; Czarniawska & Sevón, 2003), the materialization of ideas into frontline practices has received little research attention so far (Ansari et al., 2010; Helin & Sandström, 2010; Reay et al., 2013). This seems due to the tendency to focus on understanding the outcome of translation (i.e. the difference between the original idea and its translation) rather than the translation process (Teulier & Rouleau, 2013, p. 309), and to equate changes in ideas with changes in practices (Reay et al., 2013). For instance, Boxenbaum (2006) studied how a group of business actors in two Danish firms turned the concept of diversity management into a novel managerial practice, yet the article leaves the reader wondering how this practice was implemented at the frontline. Similarly, in studying how communication directors translated the idea of reputation management in Norwegian hospitals, Wæraas and Sataøen (2014) explained the occurrence of "parallel understandings and outcomes of a modified version of reputation management" (p. 243), but left aside the experience and performance of this idea in practice. Although these studies provide rich insights into the adaptation of ideas as they travel, there remains a need to further examine the "translation work" (Wæraas & Sataøen, 2014, p. 251) in frontline practices, since "ultimately, it is changes in day-to-day work that are required – not just the organizational adoption (or not) of the idea of a new practice" (Reay et al., 2013, p. 986).

The relatively few studies that examined translation processes at the frontline have shown how actors at this level may "deliberately try to translate an idea or a practice in a manner that aligns with their own interests" (Boxenbaum & Strandgaard Pedersen, 2009, p. 192). For example, Helin and Sandström (2010) studied how a corporate code of ethics imposed by an American multinational on a Swedish subsidiary was re-contextualized, re-labeled and explained by organizational members. These members implemented the code, yet simultaneously resisted it by distancing themselves from the code through devaluating its content and effect, and playing down social referents. Nyberg and Mueller (2009), in their study of a change program aimed at homogenizing cultures within the call centers of an Australian insurance company, revealed that while senior management described

its implementation as successful, locally the program was resisted as department managers, team leaders and employees kept on emphasizing differences. These studies thus underscore the importance of including the frontline level to achieve a more complete understanding of the translation process.

The relevance of the frontline level is also highlighted in the literature on 'decoupling' (Boxenbaum & Jonsson, 2008; Bromley & Powell, 2012). First, in response to new policies, *policy-practice decoupling* may occur as an organization's symbolic adoption of policies without actual changes in practices, creating legitimacy while preserving efficiency (Bromley & Powell, 2012; J. W. Meyer & Rowan, 1977). Second, due to increasing demands for transparency and accountability, organizations may also resort to *means-ends decoupling*, where policies are implemented, but "scant evidence exists to show that these activities are linked to organizational effectiveness or outcomes" (Bromley & Powell, 2012, p. 496). However, when looking at the frontline, we might find actors attempting to re-couple these disconnected policies and practices or means and ends. For example, in studying the take up of certified management systems in the field of health and safety in Danish companies, Rocha and Granerud (2011) revealed that while top management symbolically adopted these systems to gain external legitimacy, workers appropriated management's adoption motives to improve their working conditions. In addition, Kern, Laguecir and Leca (2013) examined the adoption of the casemix, a tool to measure the economic performance of patient treatment, in two French hospital departments. The authors showed that while surgeons only symbolically adopted the casemix, cardiologists coupled this tool to their own ends in budget allocation. These decoupling studies illustrate how frontline actions largely determine whether new ideas become part of everyday practice or remain as window-dressing (Bromley, Hwang & Powell, 2012), again pointing to the need to examine the frontline.

In this chapter, we join these efforts by unpacking how national activation policies are translated into organizational policies as well as into daily practices of sickness absence by networks of local actors. Based on our literature review and the three editing rules of context, formulation and logic, we formulated the following research question: How are national activation policies re-contextualized, re-labeled and defined into actions within (1) organizational policies of sickness absence, and in (2) daily sickness absence practices at the frontline? Before answering this question, we first elaborate on the activation policies in the Netherlands and Denmark and explain our research methods.

3.3 Activation policies in the Netherlands and Denmark

We focus on the activation policies of the Netherlands and Denmark, since both countries are seen as frontrunners in activating their sickness benefit systems (Etherington & Ingold, 2012; Sol et al., 2008), yet differ regarding the involvement of organizations (see Chapter 2; OECD, 2008). In light of increasing concerns about the future of the welfare state, the rise of the sickness absence rate to around seven percent in both the Netherlands and Denmark led to the idea that "sickness absence has increased to an unprecedentedly high level" that warranted political actions (Johansen et al., 2009, pp. 334-335; Yerkes, 2011). Consequently, the two countries introduced activation policies to reduce the number of sickness benefit recipients (albeit with an interval of about a decade) as an attempt to keep the welfare state financially viable in the future (Eichhorst et al., 2008). We now briefly describe the Dutch and Danish activation policies, and their implications for organizations.

In the Netherlands, activation policies were introduced since the mid-1990s as a series of regulations aimed at activating sick-listed employees to return to work, especially the Gatekeeper Improvement Act (*Wet Verbetering Poortwachter,* 2002), the Extended Compulsory Sick Pay Act (*Wet Verlenging Loondoorbetalingsverplichting bij Ziekte,* 2004) and the Work and Income according to Capacity Act (*Wet Werk en Inkomen naar Arbeidsvermogen,* 2006). Within these regulations, responsibilities were devolved from government to organizations, based on the assumptions that they are "in the best position to effectuate prevention and reintegration" (Knegt & Westerveld, 2008, p. 90) and are able to bear the costs of sickness absence (Yerkes, 2011). Consequently, organizations in the Netherlands nowadays carry the full costs of sickness absence (up to two years for each employee) and face detailed national regulations for return-to-work actions.

By contrast, when Denmark implemented its activation policies in the 2000s via national action plans, campaigns and amendments to the Sickness Benefit Act (*Lov om Sygedagpenge,* 2003, 2005, 2010), the responsibilities for activating sick-listed employees were almost fully devolved to municipalities (Johansen et al., 2008) so as to obtain a higher degree of responsiveness towards local and individual problems (Jensen, 1999).[5] Accordingly, although Danish organizations are stimulated to implement activation policies, the salary of sick-listed employees is mostly collectively covered (except for the first thirty days and potential extensions via collective agreements) and there are less strict regulations for organizations to manage the return-to-work process. The different implications of the national activation policies for organizations in the Netherlands and Denmark are displayed in Table 3.1.

5 Since this study focuses on intra-organizational dynamics, the role of municipalities (as external parties) is less prominent in this chapter.

Table 3.1 Responsibilities of Dutch and Danish organizations according to the activation policies

	The Netherlands	Denmark
Financial responsibility	Organizations pay for the first 2 years of sickness absence, at least 70% of wages per year with a maximum of 170% over 2 years	Organizations pay for the first 30 days of sickness absence, thereafter municipalities pay a reimbursement for up to 1 year
Return-to-work responsibility	Organizations are obliged (with sanctions) to take certain steps during the first 2 years of sickness absence: - Within 1 week: notification of sickness absence at occupational health physician/service - Within 6 weeks: problem analysis - Within 8 weeks: return-to-work plan - Every 6 weeks: follow-up meetings - After 46-52 weeks: first year evaluation - After 87 weeks: final evaluation, completion of return-to-work file	Organizations are urged (without sanctions) to take certain steps during sickness absence: - Within 4 weeks: sickness absence interview - Within 5 weeks: notification of sickness absence at the municipality regarding reimbursement - Possibility attest (declaration of the functional (in)capacities of the employee) - After 8 weeks: return-to-work plan (on employee's request)
Sanctions	Additional year of sick pay; paying disability benefit of partially disabled workers for max. 10 years	No sanctions
Employment protection	Generally no dismissals allowed	Dismissals are allowed

Source: *For NL: Gatekeeper Improvement Act (2002), Extended Compulsory Sick Pay Act (2004), Work and Income according to Capacity Act (2006); for DK: Sickness Benefit Act (2010)*

The aforementioned shows that the activation policies have been introduced in both countries between five and twenty years ago. It may thus be assumed that their implementation is in an advanced stage at the time of our study, rather than in a phase where actors still need to become familiar with these policies.

3.4 Methods

To unpack how national activation policies are translated into organizational policies and frontline sickness absence practices, we have applied a multiple-case embedded design (Yin, 2009, p. 47), with the four hospitals as our cases and the networks of local actors as the embedded units of analysis. Our study was conducted in the period December 2012 to August 2014.

Research setting and cases

The setting of our research consisted of healthcare organizations (hospitals), since the issue of sickness absence is especially relevant here, for two reasons. First, healthcare organizations face relatively high sickness absence rates, which has been attributed to the nature of the work, the high work pressure and far-reaching reforms of the healthcare sector (Michie & Williams, 2003). For instance, across the Netherlands and Denmark, the sickness absence rate is four percent, versus around five and six percent in healthcare in the two countries (figures for 2013; Statistics Denmark, 2015b; Statistics Netherlands, 2015a). Second, and perhaps most important in the long run, healthcare organizations are increasingly confronted with employee shortages. This problem is particularly urgent in the light of the aging (working) population, which raises the demand for care but simultaneously reduces the supply of healthcare workers (Buchan & Aiken, 2008). These pressures, together with the national activation policies, urge hospitals to manage sickness absence.

In each country, we included two hospitals in order to prevent drawing conclusions on the specifics of a single case: *City Hospital* (CH) and *Health Clinic* (HC) in the Netherlands and *Medical Center* (MC) and *Region Hospital* (RH) in Denmark (pseudonyms). These hospitals are all non-profit hospitals, located in different regions and employing between 2,500 and 5,000 employees. Although we did not explicitly sample on their sickness absence rates, these hospitals appear rather successful in managing sickness absence in terms of outcomes, with absence rates below the healthcare average and for the two Dutch hospitals even below the national average (their rates varied between 3.4 and 4.7 percent). However, these sickness absence rates say little about the actual *process* of translating national activation policies into organizational policies and frontline practices, which is the focus of our study.

Data collection

Data consisted of the hospitals' sickness absence policies (representing the organizational level) as well as interviews with frontline actors. Concerning the latter, we selected five to six networks of local actors around long-term sickness absence (i.e. absence for six weeks or longer) in each hospital, leading to a total of 21 networks of local actors. We conducted interviews with the frontline actors involved in these networks, in addition to some general interviews, resulting in a grand total of 61 interviews. An overview of the local actors by network is provided in Table 3.2; it should be noted that differences in the amount of interviews per hospital are related to variations in both the national context (e.g., Dutch organizations are obliged to involve an occupational health physician in cases of long-term absence) and the organizational strategy towards sickness absence management.

Table 3.2 Overview of networks of local actors

Network of local actors	City Hospital (CH)	Health Clinic (HC)	Medical Center (MC)	Region Hospital (RH)
1	SE/LM/HR[1]/OHP[2]/WHP[3]	SE/LM/HR[5]/WHP-1/WHP-2	SE/LM	SE/LM
2	SE/LM/HR[1]/OHP[2]/WHP[3]	SE/LM/HR[5]/WHP-3	SE/LM	SE/LM
3	SE/LM/HR/OHP[2]/WHP[3]	SE/LM/HR/WHP-4	SE/LM	SE/LM
4	SE/LM/HR[4]/OHP[2]	SE/LM/HR/WHP-1/WHP-4	SE/LM	SE/LM
5	SE/LM/HR[4]/OHP[2]	SE/LM/HR/WHP-1	SE/LM	SE/LM
6	-	-	SE/LM	-
General interviews	-	OHP	HR/UR/WHP	HR/UR
Total interviews	15	19	15	12

Notes: [1,2,3,4,5] *Equal numbers imply that the same person is involved in more than one network*

Explanation of abbreviations in order of appearance: **SE:** *sick-listed employee,* **LM:** *line manager,* **HR:** *Human Resource manager,* **OHP:** *occupational health physician,* **WHP***: work and health professional,* **UR:** *union representative*

In selecting these networks of actors, we strove for diversity regarding the cause of the absence and the age, gender, job and ward of the sick-listed employee, in order to obtain a broad view on frontline sickness absence practices. This has resulted in the inclusion of 13 networks around physical health complaints, such as musculoskeletal diseases and cancer; and eight networks around mental health complaints, like stress, depression and burnout. Diversity was furthermore achieved in terms of the sick-listed employees' jobs and wards, with 14 nurses, four nurse or nutrition assistants, two medical secretaries and one HR manager, who were all employed on different wards or belonged to a different network of actors (especially with other managers). Finally, the employees were absent for an average of 9.2 months and their age ranged from 28 to 59 years. The division of gender was skewed (three men and 18 women), but this is representative of the healthcare workforce (WHO, 2008).

Interviews were semi-structured and followed a topic list (see Appendix B). Topics covered during the interviews were (1) the actors' current job and professional background, (2) their perceptions of the cause of and solution for the sickness absence, (3) their views on their own role in the return-to-work process, (4) their perspective on the ideal and actual role of the other actors in sickness absence management, and (5) the actions that are taken, such as adjustments of work or working hours. The interviews lasted 40-60 minutes and only took longer when

respondents were involved in more than one network. All interviews were recorded and transcribed verbatim, totaling around 720 pages of transcripts.

Data analysis

We analyzed the interviews according to the stepwise process described by Eisenhardt (1989), which was facilitated by MAXQDA, a software package for qualitative data analysis. We first constructed "detailed case study write-ups" (Eisenhardt, 1989, p. 540) in order to become highly familiar with the cases and explore their uniqueness. This means that for each hospital, we summarized the perspectives of the actors in the local networks according to the aforementioned interview topics, leading to 106 pages of case study write-ups.

Second, in the cross-case analysis, we compared the hospitals regarding the three editing rules (context, formulation, logic) in translating the activation policies into sickness absence policies and practices. Since these implicit rules can only be assessed from actors' rationalizations of actions (Helin & Sandström, 2010), we scanned the hospitals' policies and the interview data on the presence of these editing rules. Regarding the rule of context, our spotlight was on the re-embedding or re-contextualization of the activation policies in a healthcare setting, which seemed easy (and even stricter) on the organizational level, but highly complicated at the frontline due to 'balancing acts' between managerial and public roles and the 'demedicalization' of sickness absence. For the rule of formulation, we focused on the re-labeling or re-framing of the activation policies in a way that makes them appropriate for the healthcare context, which revealed in the emphasis on 'disconnecting sickness and absence' in the organizational policies, and in the cherry-picking of returning to work 'as soon as possible' by frontline actors. Finally, concerning the rule of logic, we looked at the definition of actions in sickness absence management, and found a copying of 'equal treatment' on the organizational level, but the opposite emphasis on 'tailored actions' at the frontline.

3.5 Translating national activation policies in hospitals

In this section we analyze how national activation policies in the Netherlands and Denmark are (1) re-contextualized following the editing rule of *context*, (2) re-labeled according to the rule of *formulation*, and (3) defined into actions as per rule of *logic*, in both the hospitals' sickness absence policies and in frontline practices.

Context: Re-contextualizing activation policies

Organizational level

The four hospitals in our study have taken up the central idea of the activation policies to ensure the return to work of sick-listed employees by means of an active approach and a focus on remaining work capacity. For example, Health Clinic mentions, "The policy [...] is that employees who have some mobility, return to work as soon as possible, either in their own or in adjusted work". Likewise, Region Hospital describes, "The sickness absence policy should ensure a quick follow-up and an active approach in relation to work".

Although all hospitals have adopted the idea of activation, closer inspection revealed an important difference in translating the procedures of the activation policies. While the Dutch hospitals have literally copied these procedures in their organizational policies, in the Danish hospitals we observed that they are extended (e.g., with conducting follow-up meetings) or presented more strictly than prescribed by the national government (e.g., an obligation to make a return-to-work plan, regardless of whether the employee makes a request). In so doing, the Danish hospitals moved towards the stricter sickness absence policies of their Dutch counterparts. Despite the different national policy contexts, we thus perceive that at the organizational level the hospitals have installed rather homogeneous policies for sickness absence management.

Moreover, we noticed an essential addition to the national activation policies in the hospitals in both the Netherlands and Denmark. That is, while the activation policies in the two countries do not include an explicit notion on the legitimacy of absence, all hospitals distinguish between legitimate absence and frequent or atypical absence (e.g., 'Friday- and Monday-illnesses'), and measures are added to the policies in order to reduce this 'illegitimate' absence. For example, a dialogue between manager and employee is prescribed whenever the employee has been absent three or four times in 12 months (CH/HC/MC) or in five months (RH). Re-contextualization in the hospitals' policies thus means a more stringent control of sickness absence than prescribed in the national activation policies.

Frontline level

Re-contextualizing is not only relevant at the level of the organizational policies, but also (and even more) in frontline practices. Our data show that in re-embedding the national and organizational policies in their practices, especially frontline managers feel that they wear (at least) two hats in managing sickness absence: On the one hand, they need to ensure an adequate return to work of sick-listed employees, while on the other hand, they have to run a ward and make sure that other employees and patients do not suffer the consequences of the absence.

According to the managers, these goals are hard to unite, since investing their time and efforts in helping a sick-listed employee reduces the time they can spend on running daily business, including paying attention to co-workers. As Table 3.3 illustrates, re-contextualizing activation policies at the frontline requires managers to take on a hybrid role to unite public and managerial goals, which they perceive as a complex "balancing act".

Table 3.3 Re-contextualizing activation policies at the frontline: illustrations of balancing acts

CH	As a manager, you sometimes have to perform a balancing act. For the sick-listed employee, you want to get things done as well as possible, but [...] you also have a team that shouldn't be affected too much (Manager CH-3)
HC	I do my best for the sick-listed employee, without losing sight of the organization's interests. And sometimes that's a balancing act, and [...] it's not always appreciated, from both sides (Manager HC-3)
MC	You want to help the ones who are ill, but you have 60 other people to take care of too [...]. And sometimes that's difficult (Manager MC-6)
RH	I evaluate my approach [in sickness absence management] by placing two things side by side: the cost-benefit for the ward and the cost-benefit for her [the sick-listed employee]. So like, is there consensus between these two? (Manager RH-3)

Another issue for frontline managers in re-contextualizing the activation policies relates to the policies' emphasis on the remaining ability to work of sick-listed employees rather than their disabilities. Frontline actors described this as the 'demedicalization' of absence, that is, no longer "defining a problem in medical terms, [or] using medical language to describe a problem" (Conrad, 1992, p. 211). Since this new focus on abilities requires a non-medical perspective on sickness absence, it is at odds with the daily medical practices in the hospitals that are centered on (the treatment of) illnesses. Seeing that "80 percent of the team leaders are people with a medical background" (HR manager HC-1/2), demedicalization is described as particularly challenging for managers: "In the hospital, it's very difficult to apply a behavioural model [based on abilities rather than inabilities], because they [the managers] are medically trained. So in no time they are talking about medical issues" (HR manager CH-4/5).

In sum, re-contextualizing the activation policies varied between the organizational level and the frontline. While in the hospitals' policies a picture of uncomplicated compliance revealed, and even an extension of the activation policies to enable stricter absence control (e.g., by introducing measures for illegitimate absence); at the frontline a more complicated situation emerged due to

the presence of multiple and contradictory pressures (i.e. public versus managerial aims, demedicalization in a healthcare environment). These findings show the significance of re-contextualization in translation processes at the frontline, where policies have to be embedded in existing local practices.

Formulation: Re-labeling activation policies

Organizational level

Our data highlight that the appropriateness of the activation policies is described in the hospitals' policies by re-labeling them as beneficial to both the hospitals and the sick-listed employees. The hospitals frame their own interests in translation in terms of "reducing and maintaining absence at a low level" (CH/HC/RH/MC), "raising productivity" (HC) and "increasing the quality of patient care" (CH). The activation policies are thus perceived as a tool that contributes to the hospitals' main targets of healthcare quality and efficiency. Simultaneously, they are framed in the hospitals' documents as being beneficial to sick-listed employees: "(Adjusted) work is often the best medicine, next to *some* rest. The structure of being (partly) at work and having contacts with colleagues often contributes to returning to work" (HC, emphasis in original). Hence, the activation policies, and the focus on remaining (partly) at work in particular, are described as advantageous for sick-listed employees as well.

Additionally, in order to persuade actors of the appropriateness of the activation policies, three of the four hospitals explicitly stress the notion of these policies that being sick does not equal the inability to work. For example, Health Clinic uses the slogan "sickness happens, absence is a choice", and City Hospital stresses the distinction between sickness and absence as "sickness happens, absence has to be discussed". This means that although sickness might be unavoidable, being absent involves a behavioral choice that should be avoided as much as possible by seeking opportunities for adjusted work – thus providing a starting-point to support the employee. Region Hospital describes this issue as, "In general, sickness is unavoidable absence. However, the employee has the duty to cooperate actively in returning to work as soon as possible". Using these formulations, the national activation policies are framed at the organizational level as being beneficial for both organizations and sick-listed employees, and actions are justified by disconnecting sickness and absence.

Frontline level

When analyzing the re-labeling of the activation policies at the frontline, we found an even more profound formulation. Rather than emphasizing absence as a choice or a matter for discussion, workplace actors (and managers in particular) cherry-picked the phrase "as soon as possible", by which they expressed the importance

of an early (partial) return to work for the recovery of sick-listed employees. In so doing, frontline actors often prioritized the time component ('soon') instead of the ability component ('possible') in sickness absence management. This appears to be related to pressures to increase the quantity and quality of patient care, coupled with employee shortages. Having to wear two different hats, while at the same time being "very, very busy", "too busy", "so busy", or "more busy" seems to explain managers' focus on an early return to work. The emphasis on an *early* return to work in re-labeling the activation policies is illustrated in Table 3.4.

Table 3.4 Re-labeling activation policies at the frontline: illustrations

CH	I try to get them [sick-listed employees] back to the workplace quickly, even if it's just for half a day. I try to set ambitious goals; after all, you can always go slower (Manager CH-2)
HC	I think it [the national and organizational policy] has changed the work ethos, in that people are [...] saying: 'I'm paid by the hospital so I have to return to work as soon as possible' (Work and health professional-2)
MC	It's very important to come back to work as fast as possible, and perhaps do some other things than in your ordinary job (Work and health professional)
RH	The employees know [...] you have to participate actively in getting back, because otherwise there will be sanctions (Union representative)

Although frontline actors themselves only explicitly mentioned the pressures of an early return to work in relation to illegitimate absence (e.g., frequently absent employees "feel the hot breath on the backs of their necks", manager CH-2), we found that long-term sick-listed employees who cannot return to work early (in the eyes of other actors involved), feel pressured in their return-to-work process as well. These employees seem to realize that the formulation of 'choice' or 'discussion' (as in the organizational policies) does not imply a real space for negotiating options. Rather, they are requested to take an active attitude (e.g., by keeping contact with the ward, showing progress in increasing working hours) and to express their willingness to return to work. Compliance with these requests seems necessary in order to keep managers supportive in the return-to-work process, since – due to the disconnection of sickness and absence – any other (i.e. 'passive') behavior is attributed to an employee's lack of motivation. Table 3.5 illustrates the impact of re-labeling activation as an *early* return to work on employees at the frontline.

Overall, in re-labeling the national activation policies, profound editing occurred at both organizational and frontline levels, by cherry-picking those elements of these policies that support the control and reduction of sickness absence. At the organizational level, we observed that the disconnection between sickness and

Table 3.5 Impact of re-labeling activation policies in frontline practices on employees

CH	She [the manager] called me every time and pushed me to come and have coffee, because I shouldn't lose contact with the ward. [...] [I]n the beginning I just didn't feel like doing that (Employee CH-5)
HC	He [the occupational health physician] said: 'Either you're going to work more hours [...] or you can stay at home' [...] After that meeting I was so upset that I got panic attacks (Employee HC-2)
MC	I think I did it [pushing myself over my limits] because [...] I wanted to please my employer. I wanted to show him 'I want this work and I want to get back' (Employee MC-2)
RH	I wish I could have started up with some hours or less days [...], but if the department has to function we have to be there all the time [...]. They expect you to be here for a 100 percent (Employee RH-1)

absence within the national policies is used to justify activation measures in case of sickness, which are framed as benefitting the hospital as well as the sick-listed employee. Yet, at the frontline the national and organizational policies are translated even more profoundly, by cherry-picking the notion of returning to work as *soon* as possible. This translation appeared to have adverse effects on sick-listed employees who cannot live up to this expectation, and shows how the translation process involves a variety of interests, which apparently cannot all be met at once.

Logic: defining actions

Organizational level

Similar to the national activation policies prescribing (more or less strict) standard procedures to achieve equal treatment in sickness absence management, at the organizational level, we observed that all hospitals mention their policies to be "applicable to all employees" (CH/HC), in order to guarantee "overall consistency in the way sickness absence is handled" (RH), by "applying uniform rules and procedures for all employees" (MC). Whereas implementing these actions is described as the shared responsibility of employers and sick-listed employees within the activation policies, this is translated by the hospitals as managers and sick-listed employees, with the other actors (e.g., HR managers, occupational health physicians and union representatives) being given a role as advisor. As City Hospital argues, "Manager and employee are jointly responsible for making proper arrangements in relation to sickness absence; others have an advisory role". Hence, the hospitals aim to ensure the equal treatment of sick-listed employees via standard procedures, for which manager and employee are jointly responsible.

Table 3.6 Tailored actions at the frontline: illustrations

CH	You have to be able to play with the rules of the game, so that you can create reasonable solutions for all parties [...]. So I think there should be some room for maneuver (HR manager CH-4/5)
HC	The sickness absence policy [...] is a tool, but it should remain tailored to the individual, because you can't lump all absence cases together as if they were the same (Work and health professional-1)
MC	Of course we have to follow the rules, but [...] you can follow the rules more or less strictly and you can be flexible, because I think the focus should be on the employee (HR manager)
RH	I think every sickness is individual and I will manage it individually. I don't think there's a uniform recipe (Manager RH-1)

Frontline level

Despite the discursive support for the activation policies shown in the rule of context and formulation, our data reveal that this support is not followed by a translation of prescribed actions. We observed that frontline actors disagree with using the standard procedures of the national and organizational policies, and emphasize applying tailored actions instead, thereby rendering the prescribed procedures less legitimate. Table 3.6 shows how frontline actors in the four hospitals perceive the importance of discretion and tailor-made practices in the translation of activation policies into actions.

However, applying tailored actions does not mean that frontline actors always strive for the most appropriate return-to-work process, or know how to do so. Rather, we noticed that when actors do not follow the national and organizational procedures appropriately (e.g., when they do not make return-to-work plans, deviate from established time frames, or install too strict time frames), this seriously impedes the return-to-work process. Consider the following example of a network around a nurse at Medical Center who was absent because of a depression, where the manager did not see the necessity to make a return-to-work plan:

> *No, I didn't make it [the return-to-work plan]. It's more a kind of gut feeling, what can I do to get her back, how can I make her see the positive of going back to work? (Manager MC-2)*

However, for the sick-listed nurse, a structured return-to-work plan appeared to be "the main thing in getting back":

> *The one thing I was missing was an overview. I couldn't deal with all the pressures and all the things I didn't know about what would happen (Employee MC-2)*

Another example concerns a local network at Region Hospital around a medical secretary who was absent for a cancer treatment. The manager explained how she still has to push the employee for a quicker return to work, although a return-to-work plan was agreed upon:

> *I think it's taking a long time to get to the normal work[ing hours]. [...] We have reached a limit where we have to get her to work more (Manager RH-5)*

Simultaneously, the sick-listed secretary mentioned how she felt pressured when her manager tried to deviate from the established time frame at every meeting, as it impeded her return to work:

> *It [the meeting] always ended up with 'do you think you can take some more hours now?' [...] Instead of, when [...] we made an agreement of 'this is how it's going to be', then leave it [at that] rather than pushing all the time (Employee RH-5)*

Although the frontline actors' preference for tailored actions sounds intuitively more appealing than the use of standard procedures, the return-to-work process thus frequently appeared obstructed by a custom-made approach, since it was often based on the hospital's business interest of an early return to work. Only when actions were also based on an understanding of the employee's needs (in terms of time frames and work adjustments), returning to work proceeded without problems.

While discursive support for the activation policies was shown at the organizational and frontline level in re-contextualizing and re-labeling, this support does not result in a copying of the actions defined at the national and organizational level. Instead, the prescribed actions often proved not to be translated in frontline actions as intended, but rather in a way that merely pushes for an early return to work.

In conclusion, by means of Sahlin-Andersson's (1996) three editing rules, we have shown how national activation policies in the Netherlands and Denmark are modified in different ways when they are translated at the organizational and frontline level. While re-contextualizing, re-labeling and defining actions in the hospitals' policies mainly revealed compliance with the activation policies, yet in a more stringent sense (e.g., with a focus on control); at the frontline level, we found a sharp discrepancy between (discursive support for) the national and organizational policies and frontline actions. These findings were noticeably similar across the hospitals and the two countries, even despite different national pressures.

3.6 Discussion

This chapter unpacked how national activation policies are translated into the daily management of sickness absence. In this section, we describe how our findings may advance the scholarly literature on translation.

Connecting editing rules on multiple levels

The application of the three editing rules (Sahlin-Andersson, 1996) in our study enabled us to understand how the translation process occurs in everyday practices, addressing an important gap in translation research (Helin & Sandström, 2010; Reay et al., 2013; Teulier & Rouleau, 2013). Each editing rule contributed to understanding the translation process in its own way.

The rule of context illuminated the often neglected role of the wider context in the process of translation (Waldorff, 2010), and especially showed the impact of the specific (healthcare) setting on further translations in the rules of formulation and logic. This is recognized by Sahlin and Wedlin (2008), who stated that "[a]t first glance, editing processes might seem to be creative and open-ended", yet on closer inspection, "edited stories reveal how [...] translations were formed by the institutional setting in which they were performed" (p. 225). We showed how frontline managers translated the activation policies in their daily practices by adding a strong focus on the 'soon' of returning to work and neglecting the national and organizational procedures for the sake of 'tailored actions'. On the surface, this seemed to indicate room for discretion and individual choice, but our analysis revealed how managers' behavior was strongly affected by the hospital setting with its strong pressures on efficiency and a specific (medical) way of dealing with sickness absence. This institutional setting seemed more influential than the different national policy contexts, since the translation process appeared rather homogeneous in the four hospitals across the Netherlands and Denmark.

The rules of formulation and logic clarified the distinction between the framing of the activation policies and the translation of these policies into actions, respectively. Especially at the frontline, we found that the rationale for actions was informed by, but not necessarily followed the framing of the policies at this level. More importantly, the interconnectedness of both rules also occurred *across* levels. For instance, while we observed how frontline actors framed an early return to work as especially beneficial for sick-listed employees, their logic of action centered on the hospitals' efficiency goals rather than the wellbeing of employees. The one-sided emphasis on efficiency did not stem from actors' formulations at the frontline, but was rationalized by the separation of sickness and absence in the organizational policies ('absence is a choice'). In order to understand the materialization of ideas

into everyday practices, our findings herewith point to the importance of linking the different, yet interconnected editing rules of formulation and logic, where the former is more about "justifying and legitimizing language" while the latter entails "the materialization of a concept into practice" (Waldorff, 2010, p. 23). What is more, by combining the analytical framework of the three editing rules (context, formulation and logic) with the study of translation in organizational policies as well as in frontline practices, our research stresses the need to take a multi-level approach in translation studies.

Cherry-picking as translation work at the frontline

The translation work in our study can be perceived as an instance of selective coupling (Pache & Santos, 2013b) at the frontline, which we call 'cherry-picking'. That is, institutional pressures (here, the national activation policies) and organizational practices that were once loosely connected become tightly coupled (Hallett, 2010, p. 53) by selecting the best or most desirable elements of these pressures (Vedung, 2015). For example, we observed that by stressing the time component of the national activation policies (i.e. an '*early* return to work'), frontline actors (and managers in particular) translated those aspects of the activation policies that aligned with the hospital's business interests. The national activation policies were thus implemented in the Dutch and Danish hospitals, yet in a way that supports organizational practices more than public welfare goals. These findings add to our understanding of how and why frontline actors may play an important role in the materialization of policies into practices by cherry-picking policy elements.

Reflecting on the decoupling literature, our research revealed that instead of symbolically adopting policies but not implementing them in practice (policy-practice decoupling), or implementing policies without establishing a clear link to core organizational goals (means-ends decoupling; Bromley & Powell, 2012), the frontline actors in our study selectively engaged with national activation policies in their sickness absence practices in a manner that clearly links to organizational goals of efficiency. Frontline actors thus did not resist the activation policies (in fact, they all saw the value of these policies), but translated them in a way that fits the hospital's business purposes.

This cherry-picking was not so much a deliberate action of frontline managers to let the business interests of the hospitals prevail. Cherry-picking the time component of the activation policies enabled frontline managers to "carve out a space for autonomy that could allow them to go on with their [managerial] work" (Helin & Sandström, 2010, p. 596), while simultaneously complying with their public role following the national policies. Although perceived as a balancing act,

managers succeeded to combine both roles by (unintentionally) separating their talk (as in the editing rule of formulation) from their actions (as per rule of logic) (see also Brunsson, 2003). Whereas managers' talk helped them to perform a public and caring role (by arguing for the benefits of an early return to work for the recovery of sick-listed employees), their actions contributed to fulfilling a managerial role (by pushing for a quick return to work, regardless of the employee's needs), thereby solving the frontline managers' internal conflicts. In this way, our findings contribute to previous research on the influence of (multiple) institutional pressures on the translation process (e.g., Lindberg, 2014; Waldorff, 2013), by showing how cherry-picking enables actors to merge the demands arising from national policies with other existing pressures in everyday frontline practices.

Varieties of interests in translation processes

A third contribution of our study relates to the consideration of interests in translation processes. Our findings highlight that the translation process should be seen as "a battle between competing interpretations vying for supremacy", where different actors have different potentials to influence the accomplishment of their interests (Johnson & Hagström, 2005, p. 372). We showed that the interests of the actors who represent 'the employer' were often met at the expense of those of sick-listed employees. Given that translation processes involve a multiplicity of actors, our research underscores the necessity for translation studies to not only examine the interests of the "idea seller" (in our case, national governments), but also those of multiple "idea-translators" in their micro-interactional work (Mueller & Whittle, 2011, p. 192/203). This goes further than including actors in key strategic positions (e.g., top managers), but also the subordinate actors at the frontline (Rocha & Granerud, 2011). In our study, we addressed this issue by including networks of local actors.

Our findings reflect the unequal power positions in translation processes, and the fact that managers in our study ultimately seemed to hold the "trump card" (Seing et al., 2012, p. 563) in decisions about return-to-work issues, for example about the timing and pace of the return to work. This inequality in power positions seems the consequence of making one person (the manager) responsible for managing sickness absence, as in the hospitals' policies, while that person also has clear interests in running a ward. Hence, these findings call for translation studies that explicitly zoom in on the interests and the interactional work of multiple actors, and their consequences for the process and outcome of translation.

3.7 Conclusion

Although the introduction of national activation policies has ascribed an increasingly important role to organizations in sickness absence management, so far, little is known of how these policies are translated into the day-to-day management of sickness absence. At the same time, our theoretical understanding of how translation occurs in practice is rather limited. In addressing these gaps, a detailed examination of organizational policies and 21 networks of local actors in two Dutch and two Danish hospitals revealed a discrepancy between the aims of the activation policies and local sickness absence practices, as the result of the translation of these policies by multiple frontline actors. By applying Sahlin-Andersson's (1996) three editing rules, we uncovered how the activation policies were coupled to existing sickness absence practices by cherry-picking those aspects of these policies that serve the organization's business interests – although this approach often ran counter to the interests of sick-listed employees. These findings highlight the need for translation studies to incorporate multiple interacting actors and their sayings and doings in a multi-level approach.


macro level
meso level
micro level

CHAPTER 4

Quid pro quo: Understanding the role of social interactions in translation processes

An earlier version of this chapter was presented as a paper at the 2014 European Group for Organizational Studies (EGOS) Conference, Rotterdam, the Netherlands, July 3-5, subtheme 60: 'Rethinking responses to organizational complexity', as Vossen, E., & Van Gestel, N. (2014). The complexity of individual responses to institutional logics: The case of the activation logic in sickness absence management.

In this chapter, we examine the role of social interactions in translating macro-ideas into micro-level practices. The macro-idea under study is the 'activation paradigm' that is paramount in European welfare states and is to be translated into local sickness absence practices, which we studied within four hospitals across the Netherlands and Denmark. While social interactions involved in the translation process have remained relatively unexplored in institutional studies so far, we use social exchange theory to complement the translation approach. Using a case study design, our findings reveal that the managers' translation of the activation paradigm varies along with their positive or negative perception of past and present social interactions with their sick-listed employees. We also find that the link between the activation paradigm and its implementation in practice is stronger when managers' perceptions of the social interaction are negative rather than positive. This chapter highlights the importance of social interactions in understanding the macro-micro linkage between macro-ideas and practices within organizations.

4.1 Introduction

Within institutional theory, translation refers to "the more or less deliberate transformation of practices and/or ideas that happens when various actors try to transfer and implement them" (Røvik, 2011, p. 642). Although translation thus ascribes an active role to actors in interpreting and enacting new ideas in local practices (Boxenbaum & Strandgaard Pedersen, 2009; Sahlin & Wedlin, 2008), the 'micro-interactional work' through which ideas are translated on local levels has been largely overlooked so far (Mueller & Whittle, 2011, p. 189). Recently, institutional scholars call for more attention to the process through which ideas (or policies, practices) "wind their way through organizations" (Ansari et al., 2010, p. 67; Helin & Sandström, 2010; Morris & Lancaster, 2006; Nicolini, 2010; Reay et al., 2013). They argue that the translation approach, which is central to Scandinavian institutionalism (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996), not only needs to focus on the *outcome* of translation in terms of changes in travelling ideas, but also on the *process* through which ideas are translated into frontline practices in a way that fits the interests of local actors (Ansari et al., 2010; Reay et al., 2013; Teulier & Rouleau, 2013). Given that "the translation process never takes place independently of social power relationships" (Johnson & Hagström, 2005, p. 373) and social interactions thus "comprise a major part of the very 'stuff' involved in translating ideas" (Mueller & Whittle, 2011, p. 189), it seems warranted to include social interactions in examining the translation process.

Hence, in this paper, we aim to understand the role of social interactions in translation processes. The research question is: What role do social interactions play in the translation of macro-ideas into micro-level practices? The micro-level practices in this study entail the sickness absence practices of local managers within hospitals. The macro-idea to be translated is the 'activation paradigm', a profound idea that is adopted since the 1990s by many European countries to curb sharply rising welfare costs (Bothfeld & Betzelt, 2011; Serrano Pascual, 2007; Weishaupt, 2011). In short, the activation paradigm stresses 'work' – or a higher employment rate – as the solution to keep the welfare state financially viable, which requires the inclusion of people with disabilities (Eichhorst et al., 2008; OECD, 2010). In the area of sickness absence, the activation paradigm implies that being sick no longer equals the inability to work. In contrast to previous ideas that stress '(bed) rest' for treating health problems (MacEachen et al., 2007), the activation paradigm emphasizes that most sick-listed employees have "some 'healthy' capacity that can be discovered alongside the reduced capacity for work" (Hetzler, 2009, p. 376), and that can be used to perform adjusted work. To put this idea into practice, employers (usually the direct managers of employees) have been ascribed an increased role in activating sick-listed employees to return to work (OECD, 2010).

Although the macro-idea of activation has become a legitimate discourse at the political level to address the mobilization of benefit recipients to take up or remain at work (Weishaupt, 2011), knowledge of its actual implementation in practice is limited (Eichhorst et al., 2008; OECD, 2010) and critical comments have been voiced more recently (e.g., Bothfeld & Betzelt, 2011; Hetzler, 2009; MacEachen et al., 2007). Studies have pointed to sick-listed employees' experiences of being pushed to return to work (Taylor, Baldry, Bain & Ellis, 2003; Taylor, Cunningham, Newsome & Scholarios, 2010), and warned against the possible use of stronger hiring criteria based on health conditions instead of the inclusion of people with disabilities at the workplace (OECD, 2010). To develop a detailed view on the translation process and its consequences within organizations, in this paper we examine the role of micro-level interactions in how local managers translate the macro-idea of activation into their sickness absence practices. Our empirical setting consists of four hospitals across the Netherlands and Denmark, both countries being seen as frontrunners in national policies for activation (see the methods section below).

This chapter is organized as follows. First, we elaborate on the theoretical framework of our study, which combines the translation literature with the notion of 'social exchange', in order to put social interactions front and center. We then outline the methods of our research. Subsequently, based on 42 interviews with managers and sick-listed employees (21 dyads), our study reveals how local translations are dependent on the managers' positive or negative perception of past and present social exchanges with their employees. We show how the translation process is guided by

a ‘norm of reciprocity’, where the managers’ actions entail the scorekeeping of the discharge of obligations and successive reciprocation decisions. Hence, translation processes appear to follow a quid-pro-quo logic, based on the managers’ perception of social interactions. Finally, we discuss the implications of our findings for the translation literature and we reflect on our social exchange perspective on translation.

4.2 A social exchange perspective on translation

Despite an increasing number of studies that examine the process through which ideas are translated into local practices (e.g., Helin & Sandström, 2010; Reay et al., 2013), rather than focusing solely on its outcome in terms of the “differences between the original idea and its translation” (Teulier & Rouleau, 2013, p. 309), the social interactions involved in the translation process have remained relatively unexplored to date (Mueller & Whittle, 2011). This seems partly due to the tendency to study the translation process from the perspective of a single group of actors (e.g., Boxenbaum, 2006; Teulier & Rouleau, 2013; Wæraas & Sataøen, 2014). For instance, Van Gestel and Nyberg (2009) revealed the process through which national sickness absence policies were translated in Dutch law firms, and showed how the national policies’ focus on managing long-term absence was shifted to controlling the short-term absence of certain groups of distrusted employees. However, since the authors centered on the perspective of HR managers, they left aside “the interaction of various interests in the translation process” (p. 557). Other studies included the perspectives of different translators, but did not explicitly address their interactions (e.g., Nicolini, 2010; Waldorff, 2013). Waldorff (2013), for example, showed how various groups of actors in 18 Danish municipalities translated the idea of the health care center into three distinct organizational innovations, yet, as the author noted, “[t]he design of this study did not facilitate an in depth analysis of the interaction between actor groups in each municipality” (p. 232). Although these studies have increased our understanding of the translation process, the translation approach seems in need of a “sophisticated set of concepts to understand the detailed, micro-level interactions through which ideas are translated” (Mueller & Whittle, 2011, p. 189).

To explain how social interactions at local levels affect the meaning and enactment of macro-ideas, some scholars used the ‘inhabited institutions approach’ (Hallett & Ventresca, 2006) that aims to bring “work activity, social interaction, and local meaning-making back into the picture” in institutional theory (Hallett, 2010, p. 66; Delbridge & Edwards, 2013). For example, Hallett (2010) examined how the principal of an elementary school implemented new ideas for accountability in monitoring practices. Since these practices conflicted with the established autonomy of teachers, they – in their turn – constructed a negative collective

meaning of the new practices, in order to prevent the coupling of accountability ideas to their teaching practices. As another example, Binder (2007) showed how the directors of three departments within one transitional housing organization in the US responded differently to federal funding policies, based on their professional values, interests, but also on their interactions with co-workers. While these studies point to the relevance of social interactions in studying implementation processes, the inhabited institutions approach apparently does not yet offer "an infrastructure for understanding how inhabitants across similar organizations translate and twist these larger institutional meanings in ways that are both similar and different" (Fine & Hallet, 2014, p. 13). The translation approach is able to provide such a foundation, but – as we saw above – needs a vehicle to understand the micro-interactional work that occurs during translation processes.

In this study, we propose that combining the translation approach with the notion of social exchange may enable a better insight into the role of social interactions in the translation of ideas. Social exchange theory (SET) aims to understand workplace behavior (Cropanzano & Mitchell, 2005) by examining "interpersonal interactions from an exchange perspective in which social costs and benefits are 'traded' in relationships governed by normative rules and agreements" (Di Domenico et al., 2009, p. 890). The core normative rule in SET is the 'norm of reciprocity', which entails that each participant in a social exchange should repay any social benefit or service received (Cropanzano & Mitchell, 2005; Lioukas & Reuer, 2015). Although the notion of social exchange has not been explicitly linked to translation, a few authors demonstrated the potential usefulness of SET to understand the spread of ideas. Westphal and Zajac (1997), for instance, revealed how the dissemination of the practice of corporate board independence in US organizations was either impeded or facilitated depending on whether CEO-directors reciprocated or defected social exchanges with other CEOs. Similarly, Westphal, Park, McDonald and Hayward (2012) showed how the receipt of impression management support from another CEO increased the likelihood of reciprocation towards the benefactor, and even towards other CEOs. These studies highlight how the spread of ideas is influenced by the occurrence (or not) of reciprocity in social exchanges, and suggest the potential relevance of SET in unpacking social interactions in translation processes.

To best align SET with our translation approach linking macro-ideas to micro-level practices and interactional work, we choose Blau's (1964) interpretation of SET out of the different theoretical perspectives subsumed under this theory (Cropanzano, Rupp, Mohler & Schminke, 2001; Mitchell, Cropanzano & Quisenberry, 2012), since it "probably presents the most comprehensive portrayal of the context of exchanges" (Coyle-Shapiro & Conway, 2004, p. 11). According to Blau (1964), social structures provide the guiding norms and principles for subsequent (inter) action in groups as well as dyads, which is essential for social exchanges to

persist: "Without social norms [...] the trust required for social exchange would be jeopardized, and social exchange could not serve as a self-regulating mechanism within the limits of these norms" (p. 255). Institutional norms and principles result from the differentiation of power in group social exchanges (as one member is able to provide more benefits than others), the legitimation of these power differences (as the benefits received from the 'superior' member outweigh the costs of compliance), and the resulting organization of individuals and groups in common endeavors. This might subsequently lead to the emergence of institutions, since members become interested in preserving the established order and its accompanying norms and principles. In Blau's (1964) version of SET, social exchanges thus constitute the microfoundation of social structure, and these structures – in their turn – provide "certain 'rules' of exchange" (Cropanzano & Mitchell, 2005, p. 875).

Here, we examine social exchange at the workplace in the dyad between employer (i.e. manager) and employee, in its institutional context and guided by a norm of reciprocity (Coyle-Shapiro & Conway, 2004). Blau (1964) defined a dyadic social exchange relationship as "the joint product of the actions of both individuals, with the action of each being dependent on those of the other" (p. 4). A social exchange starts as a voluntary action of one individual (A) towards another person (B), which is driven by the expected social benefits that can be obtained through interactions with B (e.g., commitment, social acceptance, respect). In this way, translating macro-ideas can be seen as a kind of inducement, since actors gain social acceptance and are able to prevent feelings of guilt in return for their conformity to the social norms put forward by these ideas (Blau, 1964). As a consequence of actor A's action, a general expectation for B is created to reciprocate actor A by providing a benefit or service in the future, which may again be expressed in conformity to social norms. In so doing, a norm of reciprocity is created, as the basis for "perpetuating the ongoing fulfillment of obligations and strengthening indebtedness" (Coyle-Shapiro & Conway, 2004, p. 9). To illustrate, Song, Tsui and Law (2009) found that CEOs who are perceived to care for the needs of employees and to make long-term investments in employment relationships, were reciprocated by their employees with strong commitment and high performance.

Since the social obligations involved in social exchanges are unspecified in terms of their content and timing, how and when reciprocation should occur is usually unclear and left to the discretion of B (Shore, Tetrick, Lynch & Barksdale, 2006). This open-endedness may create a "space for translation" (Sahlin-Andersson, 1996, p. 79) where macro-ideas and their social norms are accepted, modified, deflected, betrayed, added to, appropriated, or dropped (Nicolini, 2010, p. 1013; Latour, 1986) in reciprocation. However, the continuity of a social exchange necessitates a feeling of trust that B (and A, vice versa) will discharge his or her obligation, and that neither side will engage in self-interested or opportunistic behavior, as

this would violate social norms of appropriate conduct and especially the norms of reciprocity that both actors have "internalized and institutionalized in their relationship" (Lioukas & Reuer, 2015, p. 6). Thus, when mutual trust is obtained, the social exchange may continue as long as obligations are fulfilled (Blau, 1964), although during each exchange, the idea to be traded is likely to be continuously reinterpreted and transformed in order to fit the interests of the parties involved (Czarniawska & Joerges, 1996; Nicolini, 2010). Based on the above, we believe that combining the translation approach with SET enables a better insight into the role of social interactions in translation processes.

4.3 Methods

Research setting

To study how managers translate the activation paradigm into sickness absence practices in social interactions with their employees, we focused on the Netherlands and Denmark, being seen as leading examples regarding the adoption of the activation paradigm in national sickness absence policies (Etherington & Ingold, 2012; Sol et al., 2008). Consequently, organizations in both countries are nowadays faced with national policies to 'activate' sick-listed employees. The national policies in both countries stimulate the process of returning to work via procedural guidelines for organizations, for example, to analyze the functional (in)capacities of sick-listed employees, to develop a return-to-work plan and to take related follow-up steps in case of sickness absence. Dutch employers even bear the full financial responsibilities during sickness absence for up to two years (for an in-depth study of the national policies in the Netherlands and Denmark, see Chapter 2).

To avoid basing conclusions on the specific "entanglements of organizational life" (Bechky, 2011, p. 1162), the translators in our study were selected from two Dutch and two Danish hospitals. We chose to conduct our study within hospitals, since they are internationally comparable in terms of their services and structure. Moreover, the issue of sickness absence is particularly urgent in healthcare organizations: sickness absence rates are, on average, higher in the healthcare sector compared to other industries (e.g., the professional and financial services sectors; Statistics Denmark, 2015b; Statistics Netherlands, 2015a). More generally, public expenditures are highest on healthcare, after those on social security (OECD, 2014), and are expected to grow even more as a result of the aging population, which increases the demand for care and simultaneously reduces the supply of healthcare workers (Buchan & Aiken, 2008). The above issues make the healthcare sector a relevant research setting, and hospitals are of a convenient size to study social

exchanges between managers and employees in the translation process without violating the anonymity of participants.

The hospitals in our study (H1 and H2 in the Netherlands, and H3 and H4 in Denmark) are comparable in terms of their organization type (non-profit hospitals), staff numbers (relatively high; 3,400 fulltime equivalents on average), and capacity (between 400 and 700 beds). Sickness absence rates in the hospitals range from 3.4 to 4.7 percent, which is below the Dutch and Danish healthcare average of about five and six percent, respectively (figures for 2013; Statistics Denmark, 2015b; Statistics Netherlands, 2015a). All hospitals under study revised their sickness absence policies in the years prior to our research, and now include similar activation components, such as procedures for early contact with sick-listed employees, for a certification of the functional (in)capacities of the employee, and for a return-to-work plan. The inclusion of hospitals in these front-running countries in terms of the adoption of the activation paradigm in national sickness absence policies thus seems to allow tracing the interaction mechanisms through which translation occurs at the micro level.

Research methods

The empirical study was conducted from December 2012 to August 2014. As our units of analysis, we selected 21 manager-employee dyads (i.e. five to six dyads per hospital in both countries) revolving around long-term sickness absence, which we defined as "absenteeism during a period of six weeks or more" (Dekkers-Sanchez et al., 2008, p. 156). Per dyad, semi-structured interviews were held with the manager and the sick-listed employee separately, resulting in a total of 42 in-depth interviews. The use of matched pairs enabled a two-sided view on the dyadic social exchange, which – as we will reveal later on – turned out to be highly important, given the different perceptions of managers and employees of their social interaction, and the resulting consequences of these differences.

The sick-listed employees were selected by our contact persons, which were either HR managers or managers on occupational health and safety or return-to-work issues. In selecting from the available long-term sick-listed employees, we strove for diversity in terms of the employees' age, gender, job, ward and absence cause. This resulted in a sample of employees aged between 28 and 58 years old (42 years on average), with a job as a nurse, nutrition or nurse assistant, medical secretary or HR manager, and employed at different wards or else under the supervision of different managers. Most employees were employed in the hospital for five years or more. The sample furthermore met our desired diversity, since 13 employees were absent from work due to physical health complaints (e.g., cancer and musculoskeletal diseases), and eight employees were sick-listed because of mental health complaints (e.g., stress, burnout and depression). They were absent for an average of 9.2 months. The

division of gender was skewed (three men and 18 women), but this is representative of the labor force in the healthcare sector (WHO, 2008).

Only when the sick-listed employees gave their consent to participate, their managers were asked to participate in our study. Most of these managers were "the first level of management to whom *non-managerial* employees report" (Hales, 2005, p. 473; italics in original), such as team leaders or nurse managers. With one exception, they were all women and two-thirds of them were employed as a manager in their hospital for five years or more; only two managers were employed for a shorter time (three and six months). Most managers were thus well experienced at their management jobs.

We started each interview by explaining the research and asking permission to record the interview. In order to acquire background information of the respondents and the sickness absence, we first posed questions about their current job and tasks, and their perceptions of the cause of and solution for the absence. To solicit the opinions of respondents on the social exchange with their manager or employee, we asked questions about (1) the respondents' views on their own role and (2) on the ideal and actual role of their manager or employee in managing sickness absence, and (3) their perspective on the interactions with their manager or employee. Finally, we asked about (4) the respondents' perceptions of (the effectiveness of) the actions that are taken; that is, whether and how procedures defined in the hospital's sickness absence policies are followed (see Appendix B for the topic list and interview guide). The interviews lasted 45 to 60 minutes, with a few exceptions. They were transcribed verbatim, totaling around 400 pages of transcripts.

The data were analyzed by means of open, axial and selective coding techniques (Strauss & Corbin, 1998), which was supported by the use of MAXQDA, a software package for qualitative data analysis. Open coding involved constantly switching between and comparing the interview transcripts of the managers and the employees. We started by exploring the managers' transcripts for their perceptions of the sick-listed employees, which was triggered by recurring quotes stating that they "know their employees". We wanted to understand the content of this knowledge. Following this, the employees' transcripts were coded for their perceptions of their own role and contributions to the sickness absence process. Subsequently, we coded for instances where managers talked about their own role in the particular dyad and the actions they had taken. This step was repeated to explore examples where employees told us about the actual and ideal role of their managers, and the actions that were taken. Finally, we explored the transcripts for instances where managers and employees talked about their interactions. Based on this open coding, a list of categories emerged.

Second, in axial and selective coding, we used Strauss and Corbin's (1998) organizational scheme, which allows researchers to relate categories to subcategories

that explain the conditions leading to, and the (inter)actions and consequences resulting from these categories. We found one overarching category, which in one hospital was explicitly called the "green or red emotional bank account", referring to a manager's positive or negative conclusion about the social exchange with the employee. We discovered this phenomenon more implicitly in the other three hospitals, and defined it as the judgment by managers of the need to reciprocate sick-listed employees. This judgment appeared to arise from managers' perceptions of the behavior of sick-listed employees in past and present social exchanges, and resulted in either flexible or strict translations of the activation paradigm. This ultimately seemed to lead to either an uncomplicated or a problematic return-to-work process, depending on the match between the perceptions of the managers and those of their sick-listed employees. Our data coding structure is displayed in Figure 4.1 and reveals how managers' translations of the activation paradigm appear to entail reciprocation decisions, which are highly dependent on their positive perception ('green score') or negative perception ('red score') of the performance of their sick-listed employees in past and present social exchanges. These findings were rather similar across the hospitals as well as the two countries.

4.4 Quid pro quo: Social exchanges in translation processes

In analyzing our data, we specifically focused on how reciprocity takes shape and influences the translation process in the social exchange between managers and their employees. Our data show how the managers' translations of the macro-idea of activation are inextricably linked to their perceptions of the social exchange with their sick-listed employees. After close examination of our data, we discovered two steps in the translation process: (1) keeping score by managers as a way to classify the social exchange, and (2) deciding whether or not to reciprocate. Below we elaborate on these steps in more detail.

Managers' scorekeeping of the social exchange

Social exchanges are based on the obligation of one actor to reciprocate another actor for the benefits or services that the latter has provided (and vice versa). In this way, a norm of reciprocity is created that supports the continuous discharge of obligations and strengthens indebtedness. However, sickness absence seems to cause a breach in the social exchange between the manager and the employee, for which "the one who signs an employment contract [and becomes ill] is primarily responsible, because s/he can no longer fulfill his or her obligations" (Manager H2-5). This breach appears to prompt managers to (implicitly) evaluate whether they

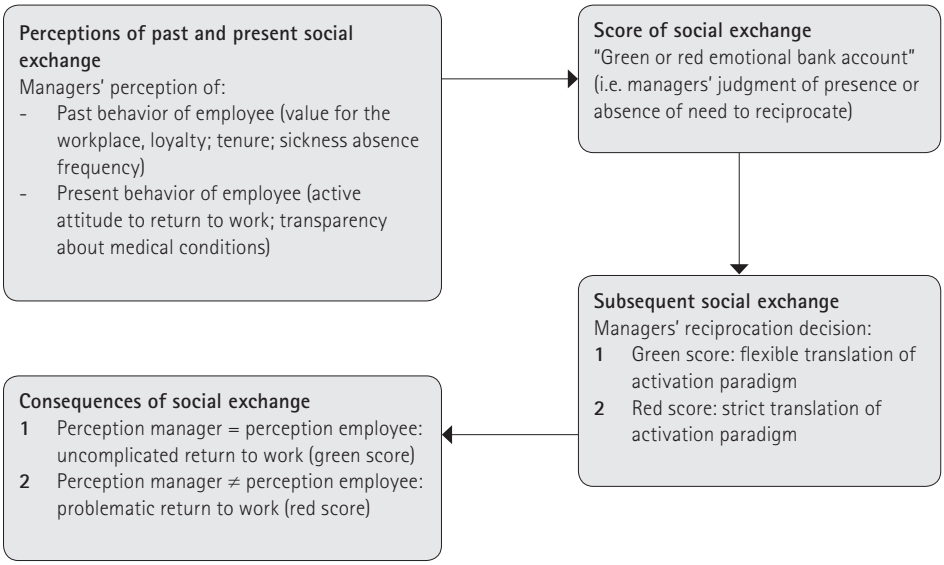

Figure 4.1 Data coding structure

still have an obligation to reciprocate the sick-listed employee (e.g., by helping with returning to work or retaining the employee). The managers in our study seemed to derive their answer from their positive or negative perception of the social exchange, which is based on a classification of sick-listed employees into being either in surplus or in deficit in terms of discharging their obligations, respectively. In one hospital, a positive perception is described as the employee having a 'green emotional bank account' (i.e. being in surplus) and a negative perception as a 'red emotional bank account' (i.e. being in deficit):

> *This is an employee who has, as we call it, a 'very green emotional bank account': she's an employee with lots of credits [...]. This also determines how your sickness absence is dealt with (Manager H1-1)*

Our study indicates that keeping score of the sick-listed employees' fulfillment of obligations affects whether managers experience an obligation to reciprocate (i.e. only for employees with a green emotional bank account) and ultimately influences how the activation paradigm is translated into sickness absence practices. Managers' scorekeeping seemed based on criteria that are related to their perception of the behavior of sick-listed employees in both past social exchanges (before the illness) and present social exchanges (during the illness of the employee). In Table 4.1 (left-hand columns) we have illustrated how and why the managers in each of our 21 cases classified their employees as either scoring 'green' or 'red' on their emotional

bank account, and how employees viewed their own discharge of obligations (right-hand column). Next, we first elaborate on the managers' criteria of scorekeeping (the left-hand columns in Table 4.1).

Past social exchange. One manager mentioned the relevance of the behavior of the sick-listed employee in past social exchanges as follows: "Every case is different, but it [the handling of the sickness absence case] also depends on the kind of employee one was before the sickness absence" (H1-5). A first criterion related to past social exchange is the managers' perception of the value of the sick-listed employee for the workplace and his or her loyalty to the organization. Apparently, having been a 'valuable' employee creates a norm of reciprocity for managers to "do something in return" (H1-3), primarily by offering more time and room to return to work.

Other criteria are the length of employment (tenure) and the frequency of sickness absence of the sick-listed employee. Employees who have a long tenure and are infrequently absent are given more credits than the ones with a short tenure and/or a high absence frequency. For instance, one manager evaluated her social exchange with a long-term sick-listed employee positively, only because of the employee's tenure of over 15 years. She explicitly mentioned that otherwise she would have evaluated the case negatively: "If I had an employee who has only been with me for a short time, it would be different: If you had been here for less than one year and were absent two to three months, that's not okay" (H4-2). It seems that sick-listed employees with a short tenure have not yet earned enough credits in the eyes of their managers to create a norm of reciprocity, and managers appear less committed to those employees. Another manager explained the importance of the employee's sickness absence frequency in determining her approach: "I hope that the employees who [seldom] get sick [...] know that they are protected in another way than the other ones who [...] are sick about four or five times in a period of six months" (H4-3).

Present social exchange. The most important criterion related to the present social exchange, is the managers' perception of the active attitude of sick-listed employees to return to work. Managers clearly valued sick-listed employees who they labeled as 'active' more than those who they considered 'passive', and were more inclined to make efforts to ensure the return to work of the former. Displaying an active attitude, for example by taking initiative to contact the manager or seeking alternative work at the department, thus seems to create a strong obligation for managers to reciprocate this behavior, as expressed by one of the managers: "She [the sick-listed employee] plays a really active role, [...] she's just thinking a way ahead [...]. So we do what we can to help her" (H4-3). Sick-listed employees also recognize the importance of showing an active attitude to return to work, as one of them illustrated: "It [the return to work] is only because [...] I showed up with an impression of willingness, that this [returning to my job] is something I want and this is what I'm

determined to do" (H3-6). A positive perception of the social exchange, in the above case based on an active attitude, thus strongly affects how the activation paradigm is translated into micro-level practices. However, some employees expressed that being more active in their return to work was too much to ask, for instance, when they were still in treatment for their illness (H4-5) or needed more time to recuperate and to get their (private) life back on track (H1-5/H3-2).

A second criterion related to the managers' perception of the present social exchange is the transparency of the sick-listed employee about his or her (dis)abilities, especially in relation to work. Being transparent reduces possible doubts of the manager about the existence and the course of the illness, and therewith improves the mutual bond of trust between manager and employee, which is key to the social exchange. Transparency about the health problems of employees is also seen as providing the manager "a tool to manage the illness" (H3-2) by giving knowledge about how to follow-up and support the sick-listed employee. However, managers might expect information about medical conditions that they deem necessary to manage the return to work, but which they are legally forbidden to ask for. Some employees 'voluntarily' cross their privacy boundaries, whereas others hold on to their legal right not to elaborate on the details of their illness but then have to suffer the consequences of a possible negative perception of their manager. This shows how the macro-idea of activation, when translated during micro-interactional work, may conflict with other macro-ideas, for example about privacy.

The above demonstrates that scorekeeping is grounded on the managers' perceptions of the obligations that sick-listed employees should fulfill. Interestingly, while these expectations about obligations have been found in all four hospitals in our study, they concern *unspecified* obligations in the social exchange (in terms of what is exactly meant by being a 'valuable' employee, having 'sufficient' tenure, being 'infrequently' absent, displaying an 'active' attitude and being 'transparent' about medical conditions). The unspecific nature of obligations makes them prone to different interpretations. For example, regarding transparency, one manager was displeased with the employee's behavior and described that "in this case, we could have talked more open about some things", while the employee labeled her behavior as transparent: "I felt like I told her [the manager] everything" (H3-6). The different (perceptions of) obligations for behavior in past and present social exchanges particularly seem to surface when sickness absence puts the social exchange under pressure, and sick-listed employees are no longer able to discharge their normal obligations to work.

Table 4.1 Perceptions of the discharge of obligations in social exchanges

Case	Manager			Employee
	Score	Criterion[a]	Perception of employee's discharge of obligations	Perception of own discharge of obligations
The Netherlands				
H1-1 Woman nurse	Green	Value for the workplace (past)	She's an employee who has a lot of knowledge; she has always been there for the workplace.	I've been at the ward for 5 years now, so [...] my leader knows that I'll always jump in [in case of problems with shifts].
H1-2 Man nutrition assistant	Red	High absence frequency (past)	He has had a lot of absence hours [...] and his absence is no longer tolerated [...] despite his medical background.	I've been called in for meetings for a few times because of my sickness absence frequency, but it is all explainable.
H1-3 Woman nurse	Green	Active attitude (present)	If you're talking about employees who want to present themselves as active, then she's really one of them.	I'm working very hard to recover, because I want to do what it takes to get it done.
H1-4 Woman nurse	Green	Active attitude (present)	She showed that she wanted to return to work and that she wanted to do what it takes.	I immediately said that this [job] is what I want to do and what I want to keep doing.
H1-5 Woman nurse	Red	No active attitude (present)	Taking initiative to recover, taking action to get something done or to change something [...] that's what went wrong.	At a certain point, I took the initiative myself to call them [...]. I think they appreciated that I took the initiative.
H2-1 Woman nutrition assistant	Green	Active attitude (present)	She's very motivated, she really wants to as well. She puts everything aside to make this work.	I do everything within my ability [to return to work].
H2-2 Woman nurse	Green	Trans-parency (present)	She's someone who is very open about what's wrong with her, also to me.	I already told her earlier that I didn't feel very well [...]. She knows that I want to do everything well and I'm very eager to move forward.
H2-3 Woman nurse	Green	Active attitude (present)	She's someone who really wants to return to work, who you don't need to motivate.	There's only one person who wants to return to work for 32 hours on this ward and that's me, [...] that's what I really want.
H2-4 Man nurse	Green	Value for the workplace (past)	He's someone with a lot of goodwill [...] and then you have to say 'you have to stop working'.	I should've kept silent about my health complaints; then I might still be working now. But I'm just too honest in that regard.
H2-5 Woman HR manager	Red	No trans-parency (present)	I notice that I'm reaching a limit, because she sometimes doesn't tell me things [...] and that's not nice.	I've always been very open about it [the health complaints] to my manager.

Case	Manager			Employee
	Score	Criterion[a]	Perception of employee's discharge of obligations	Perception of own discharge of obligations
Denmark				
H3-1 Woman nurse	Green	Value for the workplace (past)	[She] is a very important person in my department, she's very clever and good at her job.	I believe that I can get well [and return to work fully] so I don't get fired.
H3-2 Woman nurse	Red	No active attitude (present)	Sometimes from my part of the table I think, 'well, now it's time for you to get along here' [...]. [So] I have to push her.	I pushed myself because I wanted to get back to work and I wanted to please my employer, [...] to show him that [...] 'I want to get back'.
H3-3 Woman nurse	Green	Active attitude (present)	Especially this one is very active in saying 'I want to'.	I really wanted to go back to work, because I thought it was a long time to be away [from work].
H3-4 Woman nurse	Green	Active attitude (present)	She would like to come back to work.	I'm the person who doesn't want to be ill; I would like to get my life back on track.
H3-5 Woman medical secretary	Green	Active attitude (present)	I expect her to do the utmost to come back to work. And I know she wants that, she really wants that.	I would like to come back to work very much.
H3-6 Woman nurse	Red	No transparency (present)	Sometimes we didn't know what was good for her and sometimes that had to do with that she didn't tell us.	I was honest from the beginning but I didn't get it back.
H4-1 Woman nurse assistant	Red	High absence frequency (past)	I don't know her that well, [...] [but] she has been sick for many times [...]. You're not allowed to be that much ill on this ward.	I'm a very open person, so telling them [about the illness] and being active in my role [...], I think it's in my best interest and in theirs.
H4-2 Woman nurse	Green	Tenure (past)	I think there's a difference if [...] you have an employee who has been with you for 10 years and has done a good job.	I think I've done everything I could [...]. [But] they could see that [...] I wasn't very well; [...] they know me for 7 years now.
H4-3 Woman nurse assistant	Green	Low absence frequency (past)	Before [the sickness] she was fully functional, happy, glad for her work, stable, no leave of absence.	I've missed going to work; my work has been a very important thing for me.
H4-4 Man nurse	Red	No active attitude (present)	I think he has done what he could do, [...] but it was very slow and he always told me 'not so quick, I have to get back very slowly'.	She wants me to get back to work as soon as possible, but I really have to [...] be very, very conscious about how do I feel about this.
H4-5 Woman medical secretary	Red	No active attitude (present)	I expect her to work when she's here and maybe I want some more action when she's here [...] to show us that she wants this.	It's not like I go home and take a rest because that's fun, no, I go home because I need it.

Note: [a] *We have divided these cases according to the criterion of behavior in past and present social echanges that seemed primary, but it should be noted that some of the managers mentioned more than one criterion.*

Decision to reciprocate and its consequences

The open-endedness of social obligations appears to create a space for translation that enables local managers to translate the activation paradigm more or less strictly, depending on their positive or negative perception of the social exchange with their employees. More specifically, while managers seemed to reciprocate green-scoring employees by translating the activation paradigm in a flexible way, they translated this paradigm in a manner that pressures red-scoring employees to return to work as soon as possible, regardless of the employees' needs. The managers often felt entangled in a web of contextual pressures, with on the one hand the macro-idea of activation and its accompanying demands to use the sick-listed employee's residual work capacities, and on the other hand the organizational pressures to run their department as efficiently as possible. The managers described their own position in dealing with these pressures as a 'balancing act' (see Chapter 3). As one Dutch manager expressed: "I do my best for the sick-listed employee, without losing sight of the organization's interests. And sometimes that's a balancing act" (H2-3). A manager in a Danish hospital told us how she has to align the demands for social inclusion and efficiency: "I evaluate my approach [in sickness absence management] by placing two things side by side: the cost-benefit for the ward and the cost-benefit for her [the sick-listed employee]. So like, is there consensus between these two?" (H4-3). The managers' reciprocation decisions, which are based on their perceptions of the social exchange with their sick-listed employees, are thus made in a context of multiple pressures.

At the point of materializing the activation paradigm into actual practices, the perceptions of the sick-listed employees become even more relevant to gauge the consequences of managers' translations: the (mis)match between the perceptions of managers and employees regarding the latter's discharge of obligations seems to influence the return-to-work process and the employment relationship (it is now up to employees to implicitly judge whether there still is a norm of reciprocity). Below, we will elaborate on the different translations and their consequences.

Translation in case of a green score. Managers appeared to stretch the rules and regulations of the activation paradigm when they assigned sick-listed employees a green score. This translation entails that managers based their approach towards the return-to-work process primarily on the employees' needs, and postponed the requirements of the activation paradigm to give them more time and opportunities to return to work. As one manager argued, activation "shouldn't become a detention, where you have to come to work because that's better for our sickness absence rate" (H1-1). Other managers described the importance of tailoring the return-to-work process to the employees' needs by saying, "it's important that the nurse thinks it's okay, because I don't think you get anything good out of pressuring"

(H3-4) and "what I think is the most important, is what she thinks and feels. [...] I rather have her taking it slow and thinking: yes, this went well!" (H2-2). In their turn, the particular employees said about their managers, "she gave me the time and [...] the space to fully recover" (H3-4) and "my manager shows me [...] that I can take my time" (H2-2).

A flexible translation of the activation paradigm also meant postponing the dismissal of sick-listed employees. For example, one manager in a Danish hospital delayed making an analysis of the functional (in)capacities of the sick-listed employee, in order to prevent her from being dismissed, as she said: "It's a way I want to bend the rules. So every time we talked about making it [...] I said, 'let's wait' [...]. If we would have made it, she would have been fired earlier". The employee in this case noticed "that somehow they have been able to give me a long period [to return to work] and perhaps longer than the most will experience at their work" (H3-1). In general, when managers perceived the social exchange positively and responded by stretching the return-to-work procedures put forward by the activation paradigm, cases were unproblematic since the managers' perceptions were congruent with those of employees regarding their own discharge of obligations (see Table 4.1). In these cases, employees seemed very positive about being given the time and room to return to work by their managers.

Translation in case of a red score. By contrast, in case of a red score, managers seemed to translate the activation paradigm in a way that pressures employees to return to work as soon as possible, without first taking their perceptions and needs into account. For instance, while one manager told us about an employee who she labeled as passive that "if she's not showing that she can get here every day and work, maybe we have to fire her", the employee described returning to work as "a big pressure" while also undergoing an intensive treatment for her illness (H4-5). Another manager described how she only keeps calling the sick-listed employees who she perceives as passive in order to push them to return to work: "If you continue to call them to ask how they're doing [...], they feel rushed [to return to work]. For some people this isn't necessary: those [people] you need to slow down because they want too much too quickly" (H1-5). These quotes illustrate that managers do follow the requirements of the activation paradigm, but vary in their specific translations according to their perception of the social exchange.

As shown in Table 4.1, a red score and the resulting decision of the managers not to reciprocate do not match the sick-listed employees' perceptions of the extent to which obligations have been fulfilled, for example, performing well enough (H2-5), being active enough (H1-5/H3-2/H4-4), being sufficiently transparent (H3-6), or being infrequently absent (H1-2). For instance, one manager disapproved the (in her eyes) non-active behavior of the employee, saying "I expect her to work when she's here and maybe I want some more action when she's here [...] to show us that she

wants this". The employee in this case has a rather opposite view, since she felt that she does as much as she can: "it's not like I go home and take a rest because that's fun, no, I go home because I need it" (H4-5). In addition, in at least one case this mismatch occurs because the employee bases her perceptions of her own discharge of obligations on different criteria than the manager, with the employee saying that she is "very open" and "active" while her manager referred to the employee's high absence frequency (H4-1). Either way, when managers perceived the social exchange negatively, cases were problematic and disagreements most often concerned the timing and pace of the return to work. Sick-listed employees seemed to feel that the organization's interests prevailed over their wellbeing, which is marked by one employee saying: "It would have been nice if someone supported *me* more [...], [someone] who supported my wellbeing, not just getting me back quickly" (H3-5). Generally, in these red-score cases, the mismatch between perceptions of social exchanges in the translation process led to frustration for the sick-listed employees. Their perception does not seem to play a role in the managers' (negative) reciprocation decisions. Based on our data, it seems as if the criteria for social obligations as well as the different perceptions of the social exchange are not openly discussed between managers and employees.

In conclusion, managers' perceptions of the social exchange with their sick-listed employees greatly impact how they translate the activation paradigm into sickness absence practices. We found that the link between the activation paradigm and its implementation in practice is stronger when managers' perceptions of the social interaction are negative rather than positive. The implications of this paradigm thus vary for sick-listed employees, despite the aim of the activation paradigm to guarantee an equal return-to-work process for employees.

4.5 Conclusion and discussion

This chapter sought a better insight into the role of social interactions in the process of translating macro-ideas into micro-level practices. Based on the translation literature, we proposed that our understanding of this process could be improved by drawing on the notion of social exchange. We constructed a social exchange perspective on translation to examine how local managers translate the 'activation paradigm' in sickness absence practices, in interactions with their employees. Our findings revealed that translations vary along with the managers' positive perception ('green score') or negative perception ('red score') of the past and present social exchange with their sick-listed employees. Our data have thus highlighted the interactive quality of the translation process. We also found that the practical implications of the translation of the macro-idea of activation are stronger when

managers' perceptions of the social interaction with employees are negative rather than positive. Below, we discuss how our findings contribute to the existing scholarly literature on translation.

First, taking a social exchange perspective helped to better understand the role of social interactions in the translation of macro-ideas into local practices at the scope of day-to-day encounters. By focusing on social exchanges between local managers and employees, our research not only underscores that "activity at the front line matters" (Reay et al., 2013, p. 988) in the translation process, but especially reveals the relevance of social interactions between local actors in the translation of macro-ideas. We thus support the perspective that ideas are spread through "interaction and negotiation/contestation" (Sturdy, 2002, p. 132; Mueller & Whittle, 2011), yet our study further explains how these interactions involve exchanges of unspecified social obligations between local actors, and different views may occur over the discharge of these obligations. Social exchanges and, more specifically, the managers' perceptions of these exchanges then influence how macro-ideas are finally materialized into local practices. We thus argue that translation studies should not only include the sellers of ideas (e.g., at the macro level), but also the multiple "idea-translators" (Mueller & Whittle, 2011, p. 203) and their interactions at the frontline.

Using the notion of social exchange to study translation processes particularly helped to shed light on the motivations for appropriate behavior when translating macro-ideas into local practices. While in Scandinavian institutional theory, behavior is said to be driven by "internalized prescriptions of what is socially defined as normal, true, right or good" (following the logic of appropriateness) (March & Olsen, 2006, p. 690), we argue that the motivation to act appropriately depends on the presence of a norm of reciprocity. The presence of this norm, in its turn, depends on the appropriateness of the behavior of the other in the social interaction. We thus demonstrate that people are motivated (or not) to translate ideas based on their scorekeeping of the other's discharge of social obligations. In line with SET, it appears that "people are primarily concerned about whether a [...] relationship is balanced, and keep track of how far out of balance it is" (Fiske, 1992, p. 691). Hence, in combining SET and the translation approach, our findings refine the operation of the logic of appropriateness as a 'quid-pro-quo mechanism', in which the translation of macro-ideas is based on the scorekeeping of social exchanges, and subsequent reciprocation decisions.

The emphasis on the managers' *perceptions* of the social exchange in the translation process was particularly important, since – in our study – employees' views of the appropriateness of their behavior in past and present social exchanges were apparently not solicited by managers: managers and employees never seemed to communicate about their expectations of appropriate behavior. This demonstrates

how translation processes reside in the individual's (in our study, the manager's) mind, but are based on (perceptions of) social interactions. In conclusion, the notion of social exchange proved a useful tool to address the largely overlooked "micro-interactional work" (Mueller & Whittle, 2011, p. 189) involved in translation processes. Our study highlights that it is in particular the managers' perceptions of the social exchange that motivates their decision if and how to reciprocate when translating macro-ideas into local practices.

A second contribution of our study is that we have demonstrated how contextual pressures affect local social interactions in translation processes and resulting practices. We herewith respond to critiques that translation studies have paid "little attention to how the institutional context has an impact on actors' creation of a local social meaning" (Waldorff, 2010, p. 25; see also Kirckpatrick, Bullinger, Lega & Dent, 2013). Our study shows that the different kinds of translation based on green/red scores were not available to managers as written or explicit "rules to follow", but rather revealed as "rules which have been followed" as we studied the translation process in hindsight (Sahlin-Andersson, 1996, p. 85). These rule-like patterns are assumed to be formed by the institutional context in which they occur (Kirkpatrick et al., 2013; Sahlin & Wedlin, 2008).

In particular, our research shows that these contextual pressures exist at multiple levels. First, the quid-pro-quo nature of translations at the micro level can be perceived as influenced by the activation paradigm at the macro level, where a reciprocity norm is reflected in making rights on social benefits conditional on active efforts to return to work (Serrano Pascual, 2007). Second, managers need to combine this macro-idea about activation and reciprocity with organizational demands to run a department and transfer an image of appropriate (sickness absence) behavior towards co-workers and senior management in their day-to-day work. As MacEachen et al. (2007) put it, "[t]he state-mandated requirement for employers to negotiate and accommodate workers' recovery at work disrupts normal workplace social relations, which are based on the goal of production" (p. 57). The contextual pressures available at multiple levels influenced how managers defined the content of the 'quo' that is to be fulfilled in order to receive the 'quid', and therewith affect micro-level social exchanges in translation processes. Hence, we do not only demonstrate the relevance of considering the context in studies on translation, but particularly argue that this context is inherently multi-level (see also McDermott et al., 2013). In our study, the similarity in sickness absence practices across the hospitals and the two countries reveals how considering multiple demands in the local context is at least as important as including the macro-institutional context in studying translation processes (see also Waldorff, 2013).

Although the notion of social exchange has added to our understanding of translating macro-ideas into micro-level practices, we also see some limitations. One

is that it may be particularly applicable to ideas that affect reciprocal relationships, where interactions are "guided by an expectation of return or behavior in kind" (Di Domenico et al., 2009, p. 891). In our case, the activation paradigm is directly focused on the relationship between managers and employees (Knegt & Westerveld, 2008), which, in its turn, affects how this paradigm is translated. Combining the translation approach and SET thus seems especially fruitful where the implementation of ideas is dependent on "feelings of personal obligation, gratitude, and trust" (Blau, 1964, p. 94), as for instance can be expected with the materialization into local practices of diversity management (e.g., Boxenbaum, 2006) or socially responsible workforce reduction (e.g., Bergström, 2007). However, taking a social exchange perspective on translation may be less applicable when ideas do not directly influence reciprocal relationships, such as with the introduction of lean management (e.g., Morris & Lancaster, 2006) or information technology systems (e.g., Nicolini, 2010; Teulier & Rouleau, 2013). This is not to say that social interactions are not involved in the translation of these ideas, policies or practices, but they are not characterized by reciprocity or "mutual giving" (Cropanzano et al., 2001, p. 50) and hence, might be less suitable to study from a social exchange perspective.

Considering potential avenues for future research, studies into the role of social interactions in translation processes can be extended to other types of social interaction than a *dyadic* social exchange. For example, it can also be explored as a *generalized* social exchange in order to address interactions in larger groups: "generalized social exchanges take place in groups of at least three parties, and *there is no direct reciprocity among them*" (Das & Teng, 2002, p. 448; italics in original). In generalized social exchanges, it is assumed that an actor who received a benefit or service from another actor in the past, will reciprocate this behavior towards a third actor; or that an actor provides a benefit or service to another actor out of beliefs that s/he has done the same for others (Westphal et al., 2012; Westphal & Zajac, 1997). The consequences of interactions between two actors may thus go beyond the dyadic exchange, and extend to other social exchanges in the translation of ideas (e.g., see Westphal & Zajac, 1997). The previous highlights the different ways (dyadic, generalized) in which social exchanges can be insightful to enlighten our understanding of the role of social interactions in translation processes.


macro level
meso level
micro level

CHAPTER 5

'Dis-able bodied' or 'dis-able minded': Stakeholders' return-to-work experiences compared between physical and mental health conditions

This chapter is based on Vossen, E., Van Gestel, N., Van der Heijden, B.I.J.M., & Rouwette, E.A.J.A. (2016). 'Dis-able bodied' or 'dis-able minded': Stakeholders' return-to-work experiences compared between physical and mental health conditions. Disability and Rehabilitation, advance online publication, DOI: 10.3109/09638288.2016.1172675.

This chapter aims to explore if and why the return-to-work (RTW) experiences of various workplace stakeholders in the Netherlands and Denmark differ between physical and mental health conditions, and to understand the consequences of potentially different experiences for the RTW process in both health conditions. We studied 21 cases of long-term sickness absence, and held a total of 61 semi-structured interviews with the various actors involved in these cases. Our findings revealed that physical cases were seen as 'easy' and mental cases as 'difficult' to manage, based on the visibility and predictability of health complaints. On this ground, assessing work ability and following required RTW actions were perceived as more urgent in mental than in physical cases. Despite these perceptions, in practice, the assessment of work ability seemed to impair the RTW process in mental cases (but not in physical ones), and the (non-)uptake of RTW actions appeared to have similar results in both mental and physical cases. With these outcomes, the effectiveness of a differential approach is questioned, and the relevance of a bidirectional dialogue on work ability and a phased RTW plan is highlighted, regardless of the absence cause. Our study also demonstrates how policymakers need to strike a balance between obligatory and permissive legislation to better involve workplaces in RTW issues.

5.1 Introduction

During the past two decades, the main purpose of many European welfare states in case of sickness absence has changed from providing benefits, to activating sick-listed employees to return to work (RTW) early (Cox, 1998; OECD, 2010). These 'activation policies' regard work as a better form of welfare than passive benefit receipt (Weishaupt, 2011), and therefore promote an early RTW of sick-listed employees before they have reached full recovery (MacEachen, Clarke, Franche & Irvin, 2006). Hence, the focus is no longer on determining the inabilities of sick-listed employees, but on discovering their remaining ability to work, despite their illness (Hetzler, 2009). The emphasis on work has led to an increasingly important role for employers (and workplaces) in the RTW process, which is based on the belief that they are well positioned to judge what work their employees can still perform as well as the required work(place) adjustments (OECD, 2010). In so doing, employers are expected to be able to reduce the economic burden of sickness absence to society (Seing et al., 2014). Consequently, the RTW process has become the domain of a multiplicity of workplace stakeholders, such as sick-listed employees, immediate supervisors, HR managers, occupational health physicians (OHPs), unions, and

co-workers (Franche et al., 2005; Loisel et al., 2005; MacEachen et al., 2006).

Recently, researchers are catching up on their understanding of how workplace actors actually experience the RTW process, thereby revealing how workplace relations – especially those between sick-listed employees and employers (represented by supervisors and HR managers) – affect this process. Several studies demonstrated that employers appear to have the upper hand in decisions about RTW issues, for example about work(place) adjustments or the timing and speed of the RTW (Hoefsmit et al., 2013; Nyberg, 2012; Seing et al., 2012; Taylor et al., 2010). In making these decisions, employers seem to base their approach, *inter alia*, on their perceptions of the sick-listed employee's image, attitude, personality and openness about the illness in relation to work (see Chapter 4; Maiwald, De Rijk, Guzman, Schonstein & Yassi, 2011; Tiedtke, Donceel, De Rijk & Dierckx de Casterlé, 2014). Moreover, employers' actions appear influenced by the value and the replaceability of the sick-listed employee, and by the presence of goodwill and trust (Lemieux, Durand & Hong, 2011; MacEachen et al., 2006; Seing et al., 2015; Ståhl, Müssener & Svensson, 2012; Stochkendahl, Myburgh, Young & Hartvigsen, 2015; Tiedtke et al., 2012). Finally, research has pointed to the potentially facilitating role of OHPs in the RTW process (MacEachen et al., 2006), the stimulating role of unions on employers taking proactive RTW measures (Corbière et al., 2015; Franche et al., 2005), and to the relevance of co-workers in the phase before, during and after the RTW (Larsen, Labriola, Nielsen & Petersen, 2014; Tjulin, MacEachen, Stiwne & Ekberg, 2011). As such, these studies highlight the significance (and complexity) of workplace relations and multidisciplinary collaboration in the RTW process.

However, to date, empirical research that explicitly compares stakeholders' RTW experiences in cases of physical versus mental health conditions is scarce (Durand, Corbière, Coutu, Reinharz & Albert, 2014; MacEachen et al., 2006). This is because scholars have either addressed these experiences in relation to a specific symptom group, such as musculoskeletal disorders (Loisel et al., 2005; Maiwald et al., 2011), cancer (Tiedtke et al., 2014; Tiedtke et al., 2012), common mental disorders (Lemieux et al., 2011; Noordik, Nieuwenhuijsen, Varekamp, Van der Klink & Van Dijk, 2011) and depression (Corbière et al., 2015), or have not distinguished between the two health conditions in their findings (Nyberg, 2012; Seing et al., 2015; Ståhl et al., 2012; Stochkendahl et al., 2015; Taylor et al., 2010). As a result, the limited available research has proven inconclusive so far: While some literature reviews suggest the existence of similarities between RTW experiences in physical (here, musculoskeletal) and mental health conditions (Durand et al., 2014), such as the importance of work adjustments (Andersen, Nielsen & Brinkmann, 2012; MacEachen et al., 2006), qualitative studies noted differences in these experiences between both health conditions. For instance, with regard to early contact, Tjulin et al. (2011) found that supervisors and co-workers felt that the timing of the RTW should vary

between physical and mental illnesses, and Hoefsmit et al. (2013) observed that in mental cases, supervisors and employees tended to not have early contact, compared to physical cases. The inconclusiveness of evidence leaves a significant gap in the existing literature, since understanding how the RTW process can be tailored (or might not need to be tailored) to the needs of the physically or mentally sick-listed employee may promote an earlier RTW, and in so doing create a 'win-win situation' (Tiedtke et al., 2012; Tjulin, MacEachen & Ekberg, 2011) for all parties involved.

In this chapter, we therefore aim (1) to explore if and why the RTW experiences of various workplace stakeholders differ between physical and mental health conditions, and (2) to understand the consequences of potentially different experiences for the RTW process in both health conditions. Since legislation has been shown to affect workplace stakeholders' RTW behavior (Hoefsmit et al., 2013; Van Raak et al., 2005), for instance by giving actors their 'teeth' to act (De Rijk, Van Raak & Van der Made, 2007), this research examined actual RTW processes in two countries to take this influence into account: the Netherlands and Denmark. These countries are viewed as frontrunners in the 'activation' of sick-listed employees to RTW early (Etherington & Ingold, 2012; Sol et al., 2008), yet differ regarding the degree to which workplaces are given a statutory role in this process (see Chapter 2). The RTW legislation of the two countries is further explained and compared below.

5.2 Methods

To explore workplace stakeholders' RTW experiences in physical versus mental health conditions, we used a comparative multiple-case study design. This design is particularly convenient to perform a multi-stakeholder analysis, especially in unexplored research areas (Fitzgerald & Dopson, 2009). The study was conducted from December 2012 to August 2014.

Research setting

This research was carried out in four non-profit hospitals, equally divided over the Netherlands and Denmark. Workplace actors in both countries have obtained a statutory role in activating sick-listed employees to RTW early, albeit to a different extent. Legislation in the Netherlands stipulates that the RTW process is the shared responsibility of employers and employees; by contrast, since legislation in Denmark places the responsibility to initiate the RTW process with municipalities, less policy initiatives are focused on workplace actors, who are the focus of this study. As shown in Table 5.1, the Dutch RTW legislation for workplaces is characterized by extensive, obligatory 'must rules' coupled with sanctions (Van Raak et al., 2005),

Table 5.1 Legal financial and RTW responsibilities of workplace actors in the Netherlands and Denmark

	The Netherlands	Denmark
Financial responsibility	Employers pay for the first 2 year of sickness absence, at least 70% of wages per year with a maximum of 170% over 2 years	Employers pay for the first 30 days of sickness absence, thereafter municipalities pay a reimbursement for up to 1 year
RTW responsibility	- Within 1 week: notification of sickness absence at OHP/service (employer) - Within 6 weeks: problem analysis (declaration of the functional (in) capacities of the employee) (OHP) - Within 8 weeks: RTW plan (employer and employee) - Every 6 weeks: follow-up meetings (employer and employee) - After 46-52 weeks: first year evaluation (employer and employee) - After 87-91 weeks: final evaluation (employer and employee) - After 93 weeks: employee applies for disability benefit at Employment Insurance Agency	- Within 4 weeks: sickness absence interview (employer and employee) - Within 5 weeks: notification of sickness absence at the municipality (employer) - After 8 weeks: RTW plan (on employee's request) (employer and employee) - Possibility attest (declaration of the functional (in)capacities of the employee) (first page: employer and employee, second page: general physician) - Employer is allowed to ask medical certificate and statement of duration
Sanctions	For employer: third year of sick pay, paying disability benefit of partially disabled workers for max. 10 years For employee: being withhold wage payment, denied access to disability benefit after 2 years	For employer: no sanctions For employee: being withhold wage payment from employer or sickness benefit from municipality
Employment protection	Generally no dismissals possible	Possibility to dismiss

Source: *For NL: Gatekeeper Improvement Act (2002), Extended Compulsory Sick Pay Act (2004), Work and Income according to Capacity Act (2006). For DK: Sickness Benefit Act (2010)*

whereas noncompulsory 'may rules' (without sanctions) are characteristic of the Danish legislation (Chapter 2). However, despite this difference, the legislation contains similar 'activation' components in both countries, such as an analysis of the remaining work ability of sick-listed employees (i.e. the problem analysis in the Netherlands and the possibility attest in Denmark), a RTW plan, and meetings between sick-listed employees and their employers. Including these two countries with their different policies enables a better understanding of the influence of legislation on the behavior of workplace actors in the RTW process.

Sample and procedure

We included a total of 21 cases of long-term sickness absence, defined as absence for six weeks or longer, in this research (five to six cases per hospital in both the Netherlands and Denmark). These cases were purposefully selected to achieve diversity with regard to the type of the health condition (physical or mental) as well as the job and ward of the sick-listed employee, in order to include as many different workplace actors as possible. This has led to a sample consisting of 13 cases of physical illnesses (e.g., musculoskeletal disorders, neurological disorders and cancer) and eight cases of mental illnesses (common mental disorders, such as stress, burnout and depression). On average, the employees were absent from work for 9.2 months. They were all employed on different wards in the hospitals, or else had different supervisors.

The final data set consisted of 61 semi-structured interviews with the workplace actors involved in the 21 sickness absence cases. This means that in the Dutch cases, the sick-listed employee, the supervisor, the HR manager, and the OHP were included, and – where relevant – other work and health professionals. In the Danish cases, the sick-listed employee and the supervisor were interviewed as the main workplace actors involved, and in each hospital an HR manager and a union representative were interviewed. Additionally, in one Danish hospital a work and health professional was included. An overview of the interviewees and the characteristics of each sickness absence case is provided in Table 5.2; it should be noted that the difference in the number of interviews per country is related to variations in national and organizational policies (e.g., the involvement of the OHP in the RTW process is obligatory in the Netherlands but not in Denmark).

The interviews were semi-structured and guided by a topic list for both physical and mental cases (see Appendix B). Topics entailed: (1) the interviewees' current tasks and professional background, (2) their views on the cause and solution for the sickness absence, (3) their perceptions of their own role in the RTW process, (4) their perspectives on the ideal and actual roles of the other workplace actors involved, and on (5) (the effectiveness of) the RTW actions that are taken, like adjustments of the work(place) or working hours. The interviews took between 40 to 60 minutes, with a few exceptions (e.g., they could last two hours when interviewees were involved in multiple cases). They were recorded (with permission) and transcribed verbatim, leading to a total of 728 pages of transcripts.

Data analysis

Data analysis was done according to open, axial and selective coding techniques (Strauss & Corbin, 1998), supported by the use of MAXQDA, a software program for qualitative data analysis. First, the interview transcripts were coded line-by-line

Table 5.2 Overview of sickness absence cases and interviewees

Case	Employee characteristics Gender, age, position	Health condition	Interviewees[a,b]
The Netherlands			
NL-1	Woman, 35-40, nurse	Physical	SE/SV/HR[1]/OHP[2]/WHP-1
NL-2	Man, 35-40, nutrition assistant	Physical	SE/SV/HR[1]/OHP[2]/WHP-1
NL-3	Woman, 40-45, nurse	Physical	SE/SV/HR/OHP[2]/WHP-1
NL-4	Woman, 35-40, nurse	Mental	SE/SV/HR[3]/OHP[2]
NL-5	Woman, 40-45, nurse	Mental	SE/SV/HR[3]/OHP[2]
NL-6	Woman, 55-60, nutrition assistant	Physical	SE/SV/HR[4]/WHP-2/WHP-3
NL-7	Woman, 30-35, nurse	Mental	SE/SV/HR[4]/WHP-4
NL-8	Woman, 35-40, nurse	Physical	SE/SV/HR/WHP-5
NL-9	Man, 55-60, nurse	Physical	SE/SV/HR/WHP-2/WHP-5
NL-10	Woman, 55-60, HR manager	Physical	SE/SV/HR/WHP-2
N/a	Additional interview		OHP
Denmark			
DK-1	Woman, 35-40, nurse	Mental	SE/SV
DK-2	Woman, 30-35, nurse	Mental	SE/SV
DK-3	Woman, 25-30, nurse	Physical	SE/SV
DK-4	Woman, 55-60, nurse	Physical	SE/SV
DK-5	Woman, 30-35, medical secretary	Physical	SE/SV
DK-6	Woman, 30-35, nurse	Mental	SE/SV
DK-7	Woman, 35-40, nurse assistant	Physical	SE/SV
DK-8	Woman, 45-50, nurse	Mental	SE/SV
DK-9	Woman, 55-60, nurse assistant	Physical	SE/SV
DK-10	Man, 40-45, nurse	Mental	SE/SV
DK-11	Woman, 40-45, medical secretary	Physical	SE/SV
N/a	Additional interviews		HR (2)/UR (2)/WHP

Notes: [a] *Differences in the number of interviews per country are related to variations in national and organizational policies.* [b] *Explanation of abbreviations for interviewees in order of appearance:* **SE:** *sick-listed employee,* **SV:** *supervisor,* **HR:** *HR manager,* **OHP:** *occupational health physician,* **WHP***: work and health professional,* **UR:** *union representative.* [1,2,3,4] *Equal numbers imply that the same interviewee is involved in more cases.*

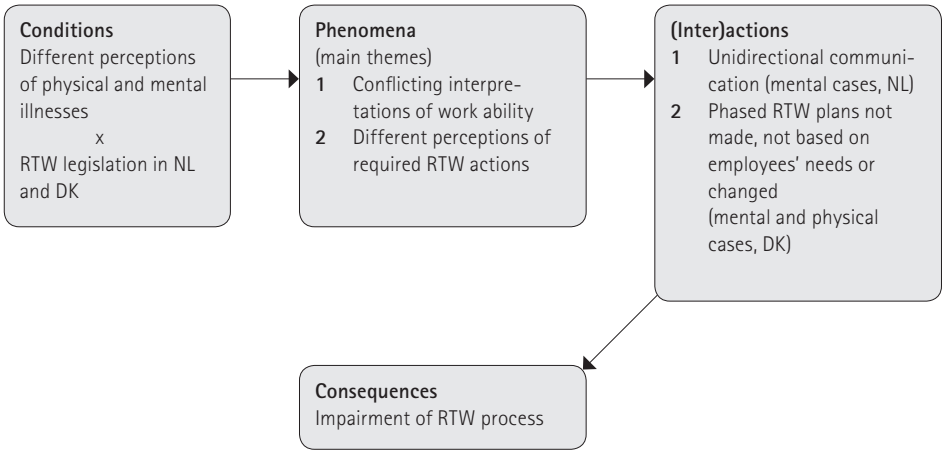

Figure 5.1 Data coding structure

Source (for picture): Hjarsbech et al. (2015).

following the topics of our topic list. We also coded for instances where workplace stakeholders made explicit distinctions between (the RTW process in case of) physical and mental illnesses. This open coding resulted in a list of categories, which we subsequently structured and elaborated using Strauss and Corbin's (1998) organizational scheme or 'paradigm'. The paradigm enables researchers to code around the axis of categories, by relating them to subcategories that define the conditions, (inter)actions and consequences leading to or flowing from these categories. Finally, in selective coding, we were able to distinguish two core categories (or phenomena) as the main themes in our comparison of workplace stakeholders' RTW experiences between physical and mental health conditions: (1) conflicting interpretations of work ability, and (2) different perceptions of required RTW actions. Figure 5.1 illustrates our data coding structure and shows how the interplay between different perceptions of physical and mental illnesses and the RTW legislation in the Netherlands and Denmark play a role in shaping our two main themes, and the resulting (inter)actions in and consequences for the RTW process.

Ethical considerations

Although approval by an ethical committee for this type of study is not required in the Netherlands and Denmark, all procedures followed were in accordance with the ethical standards laid down in the 1964 Helsinki declaration and its later amendments. The sickness absence cases were selected by our contact person within the hospitals, which was an HR manager, a manager on occupational health issues, or one of the work and health professionals. Potential participants were given written

or oral information about the research. Only when the sick-listed employees gave their consent to participate, the other actors involved in the cases were asked for their participation. Informed consent was obtained from all individual participants included in the study. Moreover, at the start of each interview, participants were assured of anonymity and confidentiality in handling the data.

5.3 Findings

In comparing stakeholders' RTW experiences between physical and mental health conditions, we will present the findings following the two main themes that have been revealed during data analysis: (1) conflicting interpretations of work ability, and (2) different perceptions of required RTW actions. The conditions, (inter)actions and consequences leading to or resulting from each theme (Figure 5.1) are woven into our storyline. Since the first theme mainly occurred in the Netherlands, we take the Dutch cases as a starting-point and compare these with the Danish ones, revealing how the assessment of work ability works out differently for mental and physical cases. By contrast, the second theme is presented by comparing the Danish cases with the Dutch ones, and demonstrates how the (non-)uptake of actions has similar implications for (inter)actions and consequences in mental and physical cases.

Conflicting interpretations of work ability

The workplace stakeholders in our study seemed to have different perceptions of physical and mental illnesses in relation to managing the RTW process. In both countries, they argued how – in their experience – physical cases are mostly 'easy' to manage because of the overall visibility of the health complaints and the general predictability of their course and duration, whereas mental cases are seen as 'difficult' due to the lack of these characteristics:

> *Physical complaints are much* easier *for everybody. There is a clear time frame and that's it, and it's much more accepted by everyone (Supervisor NL-5; emphasis added)*

> *It would be much easier if it were a broken leg or a cancer disease. When it's a depression or another kind of mental illness, it's very* difficult *to manage (Supervisor DK-2; emphasis added)*

Because of the invisibility of mental health complaints and apparent doubts about the credibility of the diagnosis (are they 'really ill'?), mentally sick-listed employees

seemingly have to work harder to prove the existence of their illness and to convince others of their (in)ability to work than physically sick-listed employees. This is illustrated by the following examples:

> **Physical illness:** *They've all seen me with my bald head [...] so then you don't need to explain (Employee NL-3)*

> **Mental illness:** *I was having a hard time telling them [about the illness], because [...] no one can see it actually (Employee DK-6)*

Starting-point: the Netherlands

In our Dutch cases, the assessment of the sick-listed employee's work ability by the OHP (the statutory problem analysis, see Table 5.1) is indeed perceived as more urgent to manage the RTW process in mental than in physical cases. As one HR manager, for instance, explained:

> *With mentally sick-listed employees, we often need the advice of the OHP. [...] In case of something physical, [like] a broken leg, it's clear: six weeks using crutches, no physical load. But in case of a burnout? [...] In those cases, the OHP and the occupational health nurse are the two players we often consult (HR manager NL-6/7)*

However, in the mental cases in our research, the 'subjectivity' of mental illnesses led to conflicting interpretations of the employee's work ability between the OHP and the sick-listed employee. That is, in their assessment of the remaining ability to work, the two OHPs included in our study seemed to doubt the severity of the illness (e.g., "people who are diagnosed with a burnout have nothing more than an adjustment disorder, are mildly overworked", NL1-5) and therefore decided that working while having a mental illness is not necessarily harmful for the sick-listed employee's recovery. Although the mentally sick-listed employees argued that they wanted to RTW as soon as possible as well, they did not share the OHP's interpretation of a full ability to work ("In the beginning, I really wasn't able to work", NL-4), and described that they needed a (slower) phased RTW.

However, upon closer inspection of the data, the conflicting interpretations per se did not seem to cause frictions between OHPs and sick-listed employees, but rather the way in which these assessments of work ability were communicated. As one of the work and health professionals described, "the OHP [of this hospital] can be confrontational, and I think that's okay, but I always say, 'it's the tone that makes the music'" (WHP-2 NL-6/9/10). Indeed, the mentally sick-listed employees argued that the OHPs' directness in stating that they were able to work without

Table 5.3 Example of conflicting interpretations of work ability in a mental case in the Netherlands

OHP *Judgement of work ability in mental cases*	99 percent of the mental health complaints that I come across are related to the private domain, and then I need to say, "the day has 24 hours, the week has 7 days, we have an employment contract for 24 hours, so you can come here [to work], it's good for you, and you have plenty of hours left to solve your problems" (NL 1-5)
Employee, supervisor and HR manager *Describing how the response of the OHP has delayed the RTW process*	In the beginning it [the RTW] took much longer because of the OHP. I told him how I felt [...] and then he said "[...] I hear that you only work 23 hours a week so you have enough time left to work on yourself, so I don't see any problem why you can't work" [...] I felt like he cut the ground from under my feet (Employee NL-5) The involvement of the OHP in this case has [...] delayed and impaired the process. [...] Of course you want an employee to RTW as soon as possible, [...] but in this case he gave such a blunt advise: "you have to return or else you'll lose your job" (Supervisor NL-5) The OHP is very firm in his judgment of mental health problems [...]. And that may backfire, so that employees don't want to RTW (HR manager NL-4/5)

having listened to their story *first*, appeared to "cut the ground from under their feet" (NL-5/7). As a result of not acknowledging the employees' illnesses, according to the supervisors and HR managers, the employees were set back in their recovery and the RTW process took longer than might have been necessary. An illustration of such a mental case is provided in Table 5.3.

By contrast, these conflicting interpretations of work ability did not occur in the physical cases, where the sick-listed employees appreciated the directness and critical view of the two OHPs in our study.

Comparing with Denmark

Although disagreements about work ability (especially in relation to the speed of the RTW) occurred in Danish mental cases as well; here, the RTW process appeared ameliorated by the inclusion of a union representative and/or a municipality councilor, who served as the sick-listed employee's 'backup'. That is, in mental cases, the union representative and the municipality councilor acted first and foremost as the employee's support (their "second pair of ears and eyes", UR DK-2). This occurred either 'front stage', by reminding the workplace actors of the rights of sick-listed employees and signaling when rules are not followed in joint meetings, or 'back stage', by explaining the employer's expectations towards sick-listed employees in conversations with the employees only. Moreover, union representatives and municipality councilors seemed able to counterbalance a supervisor's push for a (too) quick RTW, as "the little voice of morality [...] maintaining social responsibility" (UR DK-2). One employee described the role of the municipality councilor as follows:

> *He [the municipality councilor] did a great job and he was on my side, he was helping me and he was not pushing me back to work [...]. That really made a difference (Employee DK-2, mental health condition)*

Another sick-listed employee confirmed the union representative's own role description as being "a catalyst in the process" (UR DK-1):

> *It [the RTW] is only because my union person said that it would be good that I showed up with an impression of willingness, that this [returning to work] is something I want and this is what I'm determined to do (Employee DK-6, mental health condition)*

The union representative and the municipality councilor were not involved or had a less significant role in physical sickness absence cases. Only in one case (DK-11), where the RTW process did not match the department head's personal experiences with a cancer illness, the union representative had a similar role as in the mental cases.

Different perceptions of required RTW actions

According to the Dutch and Danish workplace stakeholders in this study (except for the sick-listed employees), the RTW process requires different actions based on the absence cause. While physical cases are perceived as in no need of strictly following official guidelines, because of their (generally) clearer and more predictable trajectories; mental cases are considered as requiring frequent contacts and a gradual build-up of hours and tasks according to a RTW plan, due to the subjectivity of mental health complaints and their varying trajectories and durations. As two workplace stakeholders explained:

> *People who are ill for mental reasons create such a barrier [to RTW] if they don't stay in touch with the workplace, [...] so you need to make sure that you keep in contact, even if it's only to have a cup of coffee or to go for a short walk (HR manager NL-9)*

> *You make the small [RTW] steps and have more frequent meetings with someone with a mental illness than you have in case of a bad knee or a bone break (Supervisor DK-5)*

Starting-point: Denmark

Despite these perceptions of the need for a different RTW approach according to the cause of the absence, in the Danish cases this distinction was not observed in practice. RTW plans were only made in three mental cases; in the other two mental cases these plans were only drawn up after the involvement of the union representative or the municipality councilor. By contrast, RTW plans were still made in three of the six physical cases (all concerning cancer illnesses), although – as we have shown above – workplace actors described them as less necessary in these physical situations.

What is more, the analysis revealed the importance of having and holding on to an appropriate, phased RTW plan, irrespective of the absence cause. Namely, the RTW process appeared to proceed problematically in cases of mental *as well as* physical health conditions when no RTW plan was made (i.e. no phased RTW took place), when the plan did not match the sick-listed employee's needs, or when supervisors deviated from established plans. In these situations, conflicts occurred between the sick-listed employee and the supervisor over the speed of the RTW; in physical cases especially when the RTW took longer than the expected duration. To illustrate these findings, Table 5.4 gives examples of how both physically and mentally sick-listed employees in these problematic Danish cases described the importance of a RTW plan.

Table 5.4 Examples of the importance of RTW plans for both physically and mentally sick-listed employees in Denmark

Physical cases	I wish I could have started up with some hours or less days […], but if the department has to function we have to be there all the time […]. They expect you to be here for a 100 percent (DK-7)	No RTW plan
	It [the meeting] always ended up with "do you think you can take some more hours now?" […] Instead of, when […] we made an agreement of "this is how it's going to be", then leave it [at that] rather than pushing all the time (DK-11)	Deviating from RTW plan
Mental cases	The one thing I was missing was an overview. […] Now, I have a plan on paper and I can say, "I'm not ready for this, this is what we planned". […] [So] the main thing in getting back to work was making a structured [RTW] plan (DK-2)	No RTW plan
	I heard that they make a [RTW] plan and you follow it, and I didn't have any. So from day one I was just on my own. […] I have taken the work tasks and divided them into red, yellow and green […] and then I wrote down how many hours I should work (DK-6)	No RTW plan
	I made a [RTW] plan with help from the outside, from the municipality. They helped me […] to make plans for about 14 days at a time […] and to really hold on to the plans that we were making. […] I didn't have that the first time: […] I built up hours as well, but it was too fast (DK-10)	RTW plan not based on employee's needs

Comparing with the Netherlands

In our Dutch cases, RTW plans were made in all of the physical and mental cases (with two exceptions where the physical illness was at such an advanced stage that RTW was not yet or no longer possible). Although these plans are developed for each individual case separately, increasing the amount of working hours appeared to be prioritized over building up regular tasks, as one OHP said: "the most important is returning to normal work routines (the hours and days you work) and then we accept a temporary reduction in the difficulty of tasks" (NL 1-5). This means that most sick-listed employees increased their working hours by one hour every two to four weeks, job duties were reduced to less complex tasks, and irregular shifts were temporarily cancelled. Interestingly, all of the mentally sick-listed employees started their RTW by visiting the workplace several times to have a cup of coffee, in order to keep in touch with their colleagues and to lower the threshold to RTW.

Despite a perceived need to distinguish actions according to the cause of the absence, both physically and mentally sick-listed employees in our Dutch cases appreciated the RTW plan as a support and guidance in returning to work. In particular, these employees were satisfied with how their needs were considered in establishing the RTW plan, as they mentioned, "what has contributed to the RTW was the time and space that I was given" (NL-4, mental), "they give me all the room that I need to return" (NL-6, physical) and "my manager gives me carte blanche" (NL-8, physical). Even in two of the three mental cases where the RTW process was at first impaired by conflicting interpretations of work ability, as we saw above, the sick-listed employee and the supervisor managed to make a plan that got the process back on track in a positive way. As one of the supervisors explained, this meant "partly taking on the [OHP's] advice and partly going our own way" (NL-7). Next to having and holding on to a RTW plan, basing these plans on the needs of physically and mentally sick-listed employees thus seems important for an unproblematic process of returning to work.

5.4 Discussion

The aim of this chapter was to explore if and why the RTW experiences of various workplace stakeholders in the Netherlands and Denmark differ between physical and mental health conditions, and to understand the consequences of potentially different experiences for the RTW process in both health conditions. The data revealed the existence of a discrepancy between *perceptions* of a required distinction between physical and mental cases on the one hand, and the *reality* of having to make this distinction on the other. On this ground, this study highlights the importance of (1) involving sick-listed employees in a bidirectional dialogue on work ability, (2)

establishing an adequate, phased RTW plan, regardless of the absence cause, and (3) striking a balance between 'must rules' and 'may rules' in RTW legislation aimed at involving workplaces. We discuss these key findings below.

Bidirectional dialogues on work ability

A first difference in actors' RTW experiences between physical and mental health conditions revealed in the assessment of the sick-listed employees' remaining work ability, which was perceived as more urgent in mental than in physical cases. The need to prove a mental illness confirms how doubts regarding the credibility of the diagnosis are specific to common mental disorders (Lemieux et al., 2011). However, despite this perceived need for evidence, in practice, the assessment of work ability appeared counterproductive in the mental cases in our study: conflicting interpretations of work ability (initially) impaired the RTW process. With one exception, these divergent interpretations did not occur in physical cases.

In our research, conflicts about an employee's remaining work ability seemed to stem from a lack of (sufficient) two-way communication between the employee and the OHP (in the Dutch cases) or between the employee and his or her supervisor (in the Danish cases). We found that the mentally sick-listed employees in our study were not given an equal voice, although including employees in assessing their work ability is described as a best practice to ensure active participation in the RTW process (Durand et al., 2014). The lack of voice created resistance in these employees towards an early RTW (they felt like 'the ground was cut from under their feet') and caused them to put their foot down, which delayed the RTW process. These findings are in line with earlier research showing that, on a more general level, organizational decisions fail more often when employees are not consulted (Nutt, 2002). It thus seems that the RTW process could benefit from *bi*directional communication.

In fact, bidirectional communication among stakeholders has been suggested as a potential (yet neglected) facilitator of a successful RTW (Pransky, Shaw, Franche & Clarke, 2004). Reflecting on the Danish cases in our study where frictions existed between the supervisor and the sick-listed employee, the union representative and/or the municipality councilor could ensure bidirectional communication between both actors. After their involvement, the RTW process got back on track, as employees were given a say in determining the RTW approach based on their work ability. Indeed, chances of returning to work appear significantly higher when a RTW plan is made together with the sick-listed employee, compared to when no plan is made or when it is done by the OHP or the employer solely (Oomens, Koppes, Van den Bossche & Houtman, 2010). This underscores the importance of effective communication between workplace stakeholders.

Although a greater role for employers in the RTW process is increasingly advocated, for instance by the OECD (2010), our study suggests that this should not occur without including a support for the sick-listed employee, especially in mental but also in some physical cases. This implies that the role of the union or the municipality could be further strengthened in Denmark (e.g., active involvement from the outset, in all cases), while it is not yet clear who should take this supporting role in the Netherlands. Up until now, Dutch municipalities have no statutory role in the RTW process of sick-listed employees, while Dutch (confederations of) trade unions are centrally organized at the national or sector level, and their representatives are not employed by organizations as in the Danish hospitals in our study (see Chapter 2; Van Gestel et al., 2013). Therefore, investigating which actor could fulfill a supporting role in the Netherlands remains an interesting avenue for future research.

The importance of a phased RTW plan

The discrepancy between perceptions and reality of having to make a distinction between physical and mental cases furthermore revealed regarding the implementation of RTW actions. Whereas workplace actors perceived the need to follow official procedures in 'difficult' mental cases and not in 'easy' physical ones, the findings showed that the RTW process could benefit from adequate implementation of a phased RTW plan, irrespective of the cause of the absence. The most important issue seemed to be that the RTW process (in terms of pace and timing) is based on the employee's needs, echoing Franche et al. (2005) who described that "in the *optimal* self-organized return to work, the worker is typically *asked* by the employer what s/he needs" (p. 533; italics in original). Basing actions on the needs of sick-listed employees is also recognized as a best practice in managing the RTW for employees with musculoskeletal disorders as well as for those with common mental disorders (Durand et al., 2014). This does not necessarily mean moving away from an activation approach, since virtually all the (physically and mentally) sick-listed employees in our study expressed a desire to RTW early.

The finding of the importance of a phased RTW plan is in line with quantitative evidence in the Netherlands and Denmark showing that sick-listed employees who partially RTW have a higher chance of a full RTW compared to those who do not RTW partially (Høgelund, Holm & McIntosh, 2010; Oomens et al., 2010). However, while a phased RTW appeared only effective for physically sick-listed and not for mentally sick-listed employees in Denmark (Høgelund, Holm & Eplov, 2012), our study of actors' experiences revealed how both groups of (Dutch as well as Danish) employees valued the structure, guidance and support provided by an adequate, phased RTW plan. This contradiction might be explained by the observation that all

the mentally sick-listed employees in our research mentioned the desire to RTW early (i.e. before having reached full recovery), which has been shown to reduce the time to RTW in mental cases when a phased RTW plan is made (Van Oostrom et al., 2010).

In conclusion, while workplace stakeholders perceived the necessity to treat physically and mentally sick-listed employees differently, in practice, the effectiveness of making this distinction appeared questionable, since both physically and mentally sick-listed employees seemed to benefit from having a phased RTW plan that is based on their needs.

'Must rules' versus 'may rules'

This research is one in a few that has explored the RTW process cross-nationally (e.g., Van Raak et al., 2005) and included two countries with varying RTW legislation for workplaces, ranging from strong 'must rules' in the Netherlands (Van Raak et al., 2005) to weak 'may rules' in Denmark (Chapter 2). While similar perceptions of the differences between (the RTW process for) physical and mental cases were observed, workplace actors' behavior differed between the two countries, with varying consequences for the RTW process. In our Dutch cases, and according to the legislation, RTW plans were made (where possible), but the obligatory problem analysis has led to the imposition of an activation approach on (mentally) sick-listed employees – albeit with a counterproductive effect. In our Danish cases, RTW plans were either not drawn up or not followed through in a majority of cases, but union representatives and municipality councilors appeared successful in getting the process back on track by being the 'second pair of ears and eyes' for (especially mentally) sick-listed employees.

Hence, while 'must rules' coupled with sanctions (as in the Netherlands) may increase the probability that RTW actions are taken, our explorative study revealed that these rules can also be used to push sick-listed employees to RTW quickly without considering their needs first. Previous research also showed how employers in the Netherlands used the legislation to force meetings with the sick-listed employee out of distrust regarding the employee's (in)ability to work (Hoefsmit et al., 2013). These observations nuance earlier quantitative findings suggesting that the Dutch legislation promotes the RTW of long-term sick-listed employees more than the Danish legislation (Høgelund, 2003), since statistics remain rather silent on how workplace actors actually *experience* the RTW process (MacEachen et al., 2007). It may be assumed that negative experiences, such as feelings of being pushed, impair (the sustainability of) the RTW and damage the employment relationship.

Moreover, similar to an earlier study by Stochkendahl et al. (2015), this research found that a reliance on 'may rules' does not mean that no actions are taken in Denmark. In almost half of the cases, supervisors took the responsibility to draw

up a RTW plan, while Danish labor agreements ensured that wages are paid after the mandatory wage payment period of 30 days (to four to nine weeks for blue-collar workers and to one year for white-collar workers; Confederation of Danish Employers, 2010). Moreover, while employers in Denmark are allowed to dismiss a sick-listed employee, only four of the eleven Danish employees in this study were dismissed after an average of eight months of absence, and they were given the notice period as a last chance to RTW. Based on a study comparing employers' compliance with 'must rules' and 'may rules' in Dutch and Belgian RTW legislation (Van Raak et al., 2005), a possible explanation for conformity in Denmark may be that some actors considered these 'may rules' as useful or matching their own goals.

The above suggests that neither an overreliance on 'must rules' and sanctions, nor the use of 'may rules' only should be seen as the *holy grail* in involving workplaces in RTW issues (Høgelund, 2003; Van Raak et al., 2005). To quote Van Raak et al. (2005), "[a] combination of 'must rules' and 'may rules' may be more productive, on condition that the latter correspond with internalized rules, with the goals of agents and with their ideas about useful and applicable rules" (p. 150). Hence, it seems that policymakers need to take different stakeholders and their interests into account, when designing policies that aim to involve workplaces but that simultaneously should protect and empower (sick-listed) employees.

Limitations and recommendations for future research

The strengths of our study include its comparison of physical and mental cases in natural settings involving a diverse set of workplace stakeholders, and its link with national legislation in two countries. This has enabled a more in-depth insight into the RTW process and the experiences of a multitude of workplace actors therewith. Although our research comprised an explorative study with a limited number of cases, the use of multiple data sources in terms of interviews with various workplace actors (sick-listed employees, supervisors, HR managers, union representatives, OHPs, and other work and health professionals) helped to triangulate the findings by illuminating the RTW process from different angles.

Nevertheless, due to the explorative nature of our study, further research is needed that compares RTW experiences between physical and mental health conditions, in order to verify and extend our findings. For example, while the two OHPs in our study had fairly strong opinions about mental illnesses and the possibility to RTW, other perspectives may exist among OHPs as well. Moreover, it would be worthwhile to include external stakeholders, such as medical doctors and psychologists, to investigate how their role might affect the process of, and experiences with, returning to work in physical and mental cases. Finally, since our research was conducted in four hospitals, its generalizability to other settings has

to be further investigated. It is unclear whether workplace stakeholders in sectors other than healthcare will experience the RTW process differently, for instance due to their lack of medical knowledge. Replicating our study in different sectors would therefore be an interesting avenue for future research.

5.5 Conclusion

The legislation aimed at the 'activation' of sick-listed employees in the Netherlands and Denmark does not distinguish between causes of absence; rather, it provides general procedures to manage the RTW process, regardless of the illness. Yet, by comparing the experiences of various workplace stakeholders with the RTW process in actual settings, this chapter shows how cases of physical and mental health conditions are perceived and treated differently. At the same time, the findings question the effectiveness of this differential approach, as it appears that the 'dis-able bodied' as well as the 'dis-able minded' in the two countries could benefit from a treatment (and especially a phased RTW plan) that is achieved through bidirectional dialogue, considering the needs of individual employees without necessarily moving away from an activation approach.


all directions

CHAPTER 6

General discussion

In the new activation system the same [security] net would suddenly act as a trampoline in which the same citizen on benefit [is] rapidly propelled back up into the labour market. In fact, the upward speed of the citizen [...] is so powerful in that picture [that it] makes you fear he will soon go into orbit around our planet.

(Sol et al., 2008, p. 165)

With my dissertation, I aimed to increase the scholarly understanding of the microfoundations of the activation paradigm in hospitals in the Netherlands and Denmark, by using a Scandinavian institutionalist (translation) perspective. To do so, the previous chapters addressed different building blocks of this micro-foundational understanding: the macro-level arrangement of the activation policies in terms of underlying ideas and governance systems (Chapter 2); the meso- and micro-level translation of the activation paradigm into sickness absence policies and frontline practices (Chapter 3); and the micro-level translation of the activation paradigm during dyadic interactions between local managers and sick-listed employees (Chapter 4), as well as during multi-stakeholder collaborations, compared between physical and mental cases (Chapter 5). As outlined in Chapter 2, the different governance systems of the Dutch and Danish activation policies led me to expect that the greater statutory role of employers in the Netherlands would result in employers being more actively involved in sickness absence management compared to employers in Denmark.

Answering my main research question ('*What are the microfoundations of the activation paradigm in sickness absence management, within hospitals in the Netherlands and Denmark?')*, my findings reveal that the activation paradigm has become imbricated in local practices within Dutch and Danish hospitals as a focus on the speed of the return to work. It seems that returning to work 'as *soon* as possible' – rather than 'as soon as *possible*', taking into account the possibilities of the employee – has become the main message. This observation revealed in Chapter 3, where I showed how defining the activation paradigm within the hospitals' policies by decoupling sickness and absence paved the way for local actors to translate this paradigm in a way that pushes employees for a quick return to work. Chapter 4 nuanced these findings by showing how the push for a quick return to work was primarily present in cases where the manager perceived the social exchange with his or her sick-listed employee negatively (a so-called 'red score'). Nevertheless, employees with a 'green score' already appeared to express an active attitude to return to work quickly. Finally, Chapter 5 revealed how a push for an early return to work occurred in mental cases; in physical cases only when the return to work took longer than the expected duration. In contrast to my assumption about the different

governance systems of the activation paradigm and the resulting involvement of employers in sickness absence management, my findings were remarkably similar between the Netherlands and Denmark.

What do these findings mean for theory and practice? This question is central to this final chapter. I will start off by elaborating on the contributions of my dissertation to (Scandinavian) institutional theory, followed by a discussion of its practical contributions to policymakers and businesses. Subsequently, I will reflect on the methodology of my study and provide suggestions for future research. The chapter will end with a short conclusion.

6.1 Contributions to (Scandinavian) institutional theory

A multi-level perspective on microfoundations

With my dissertation, I respond to recent calls to take a multi-level perspective in the study of institutional logics (e.g., Battilana, 2006; Reay et al., 2013; Van Gestel & Hillebrand, 2011), which remind us that "[w]ork on institutional logics is inherently cross-level, highlighting the interplay between individuals, organizations, and institutions" (Thornton & Ocasio, 2008, p. 120). By means of a translation approach, I uncovered the microfoundations of the activation paradigm and showed *why* this paradigm becomes increasingly different from its macro-level meaning, the further down the idea of activation travels within the organization.

Based on the insights gained from the previous chapters, the translation of the activation paradigm at the various levels is summarized in Table 6.1, which shows the relevance of the meso level, but especially the micro level in shaping the meaning of the activation paradigm. This finding underscores that logics do not exist by themselves, but that "it is only when the logics are enacted that they become part of practice" (Lindberg, 2014, p. 496; McPherson & Sauder, 2013). However, by taking a translation perspective, I have demonstrated that in becoming part of practice, the meaning of a logic changes in a way that diverges from its macro-level formulation. As I revealed in Chapter 3, significant changes especially occurred at the micro level through actors' 'selective coupling' of the activation paradigm to local sickness absence practices (see also Table 6.1). This highlights the importance of including frontline actors in studies on institutional logics as well as on translation. What is more, institutional logics are not translated by individual actors independently; rather, they are "generated and maintained through ongoing interactions" (Barley & Tolbert, 1997, p. 94). Since (Scandinavian) institutional theory has largely overlooked social interactions so far, studying the role of actors and their interactions required "a more developed theory of human behavior" (Thornton et al., 2012, p. 77).

Table 6.1 A multi-level perspective to arrive at the microfoundations of the activation paradigm

Macro level component of the activation paradigm[a]	Meso level translation into organizational policies[b]	Micro level translation into local practices[c]	Change as a result of translation
Underlying idea: Sickness ≠ inability to work	Disconnecting sickness and absence	Cherry-picking: selective coupling of 'early' return to work to sickness absence practices	From an early return to work (i.e. before full recovery) to returning to work as soon as possible
Underlying idea: Rights & obligations Governance system: Responsibility of employer and employee	Responsibility of both employer and employee	Quid pro quo: Scorekeeping and reciprocation of employees' discharge of obligations	From shared responsibility to the employees' responsibility
Governance system: Routines for equal treatment	Equal treatment	Differentiation according to the cause of absence	From equal treatment to differential treatment

Notes: [a] *See Chapters 1 and 2;* [b] *See Chapter 3;* [c] *From the top down, see Chapters 3, 4 and 5*

In Chapter 4, I have therefore demonstrated the usefulness of social exchange theory to address the micro-level interactions that occur during the translation of an institutional logic.

Contrary to my expectations (see Chapter 2), my findings were remarkably similar between the Netherlands and Denmark, despite the different governance systems of the activation policies in the two countries. This might again be an indication of the great(er) influence of the local context. However, it may also be that the two countries are not so different after all; for example, they have been described as comparable in terms of being "smaller, highly developed north-western European countries with a similar culture of tolerance and flexibility and with a strong commitment to social citizenship rights" (Van Oorschot & Abrahamson, 2003, p. 289). That said, taking the meso level as an example, Chapter 3 showed that both the Dutch and the Danish hospitals have adopted the idea and the procedures of the activation paradigm, with the Danish hospitals moving even closer to their Dutch counterparts (in fact, the organizational sickness absence policies were highly comparable, except for the use of sanctions in the Netherlands and the possibility to dismiss employees in Denmark). Another explanation for the similarity of findings may thus be that regulative pressures (as in the Netherlands) may be substituted by normative pressures, especially in areas where regulative pressures do not work (as in Denmark, see Chapter 2; Vasudeva, 2013). Different governance systems (in terms of responsibilities, routines and regulative instruments) might thus have a similar impact.

Overall, my research reveals the importance of studying micro-level (inter)actions to understand how macro-level institutional logics are given shape in practice. Taking a multi-level approach enables scholars to build the necessary bridge between the macro-level oriented institutional theory and micro-level (inter)actions (Battilana, 2006; Hirsch & Lounsbury, 1997), in order to achieve a better understanding of the microfoundations of an institutional logic. As became apparent in the previous chapters, the translation approach provides a fruitful starting-point for doing so.

Intra-logic complexity

A second contribution of my dissertation relates to the definition of institutional complexity, or the situation in which actors face "incompatible prescriptions from multiple institutional logics" (Greenwood et al., 2011, p. 318; see Chapter 1). While others have called for a better definition of 'incompatibility' (Greenwood et al., 2011; Smets & Jarzabkowski, 2013) as well as of 'institutional' logics (R. E. Meyer & Höllerer, 2014), my findings challenge the general assumption that institutional complexity only occurs when two or more logics are at play. More specifically, by focusing on individual responses to the activation logic, my study has shown that institutional complexity may also occur within a *single* logic. That is to say, because institutional logics are "by their very nature, [...] broad and general and therefore open to multiple interpretations" (Voronov et al., 2013, p. 1565; see also Friedland & Alford, 1991), a logic may itself be ambiguous and contradictory in its prescriptions. I will now explain and define this 'intra-logic complexity' on the basis of my findings.

On the macro level, one of the reasons for the attractiveness of the activation logic is its ambiguous and contradictory nature of promoting both the welfare of benefit recipients (which requires investments, or 'spending') and the financial viability of the welfare state (which calls for retrenchment, or 'saving'): in this way, it appeals to all stakeholders (Bothfeld & Betzelt, 2011). However, as particularly revealed in Chapters 3 and 4, this ambiguous focus on wellbeing and cost reduction becomes problematic at the micro level, since local actors perceived these foci as prescribing incompatible behaviors: they experienced a need to balance the interests of the sick-listed employee and those of the organization. In combination with existing demands to "improve access [to care], introduce the latest technologies and services [to improve the quality of care], and contain costs" (Arndt & Bigelow, 2006, p. 384), Chapter 3 showed that local actors within the hospitals translated the activation paradigm primarily as a means to reduce costs, by selectively coupling the activation paradigm to their sickness absence practices. In nuancing this finding, the subsequent chapters revealed that frontline managers interpreted the activation logic either as a way to promote the wellbeing of the sick-listed employee

or as a tool to reduce costs, depending on their positive or negative perception of the social exchange with their employee (Chapter 4) and on the cause of the illness and the (expected) absence duration (Chapter 5). Hence, the activation paradigm seems translatable in two different and seemingly contradictory ways (i.e. a focus on the wellbeing of the employee or on cost reduction), leading to different sickness absence practices (i.e. stretching the rules or pressuring employees for a quick return to work, respectively).

In sum, my research has revealed the existence of *intra-logic complexity*: the situation in which the prescriptions of a single institutional logic are subject to multiple interpretations, and these different interpretations are perceived as difficult to reconcile. As a result, different individual responses and practices may occur. To the best of my knowledge, this issue has not been addressed to date. Voronov and his colleagues (2013) touched upon intra-logic complexity, as they demonstrated how the aesthetic logic of the fine wine industry is interpretable as a focus on either the winemaking process or the output of that process. The different interpretations of this logic were related to different practices, such as farming practices in the former interpretation and experimental practices in the latter. R.E. Meyer and Höllerer (2014) suggested distinguishing between '*inter*-institutional' and '*intra*-institutional' complexity, where the latter entails a situation of competing organizational principles "within one institutional order across different cultural contexts" (p. 1227). However, this form of complexity refers to the existence of *multiple* logics within one institutional order (e.g., within one profession, as in M. B. Dunn & Jones, 2010), instead of the occurrence of multiple meanings of *one* institutional logic as in the case of intra-logic complexity.

Individual responses to institutional logics

A third contribution of my dissertation relates to understanding individual responses to institutional logics, which is an important quest in institutional theory (see Chapter 1; McPherson & Sauder, 2013; Pache & Santos, 2013a; Thornton et al., 2012). To date, researchers have paid more attention to organizational responses to institutional logics rather than to those of individuals (e.g., Battilana & Dorado, 2010; Oliver, 1991; Pache & Santos, 2010), although it is recognized that "institutions are reproduced through the everyday activities of *individuals*" (Powell & Colyvas, 2008, p. 277; emphasis added). As a result, there is a need to improve the scholarly understanding of individual responses to institutional logics. By taking a translation approach, my research adds new insights into *how* and *why* individuals may respond to an institutional logic.

First, in Chapter 3, I showed how the activation paradigm was translated into frontline practices through 'selective coupling' or 'cherry-picking', which I defined

as the tight coupling of institutional demands and local practices that were once loosely coupled, by selecting the best or most desirable elements of these demands. My study herewith extends Pache and Santos' (2013b) response of selective coupling from the management level to the frontline, and to situations in which exposure to institutional complexity is forced by regulations rather than freely sought. Moreover, while the literature on decoupling traditionally assumes the mere symbolic adoption of institutional demands in order to continue "business as usual" (Boxenbaum & Jonsson, 2008, p. 79; J. W. Meyer & Rowan, 1977), I have shown how selective coupling provides a way to implement institutional demands, yet in a way that serves business interests more than the interests of sick-listed employees. Selective coupling is thus a different, and even a safer solution to managing institutional complexity, since it avoids the risk of "being caught faking compliance" (Pache & Santos, 2013b, p. 994). In other words, individual actors actually do what they say and what they ought to do (thereby appearing legitimate), although they use "the official purpose of a policy as a rhetorical device to justify implementing that policy in ways that could be considered controversial" after closer inspection (Dick, 2015, p. 898), for example by using the activation paradigm to push sick-listed employees back to work quickly.

Second, taking a social exchange perspective on translation in Chapter 4 enabled a better understanding of the motivations to respond to an institutional logic. In this chapter, I showed how behavior does not just follow a logic of appropriateness as is traditionally assumed within (Scandinavian) institutional theory (March & Olsen, 2006), but rather that the motivation to act appropriately depends on the presence of a 'norm of reciprocity', which – in its turn – is based on the appropriateness of the behavior of the other in the social interaction. Responses to institutional logics thus seem motivated by a 'quid-pro-quo mechanism', where individual actors are involved in a process of scorekeeping and reciprocation. In addition to uncovering the motivations underlying individual responses, Chapter 4 underlines how social interactions are crucial to understand the actual impact of institutional logics on individual behavior. While it has been recognized that "it is through social interaction that institutions are interpreted and modified" (Hallett & Ventresca, 2006, p. 215), so far most institutional studies "have much of the social dynamics involved as a closed, black box" (Zilber, 2013, p. 81). My dissertation contributes to the existing scholarly literature by showing the relevance of social interactions in determining how an institutional logic is given shape on the ground, for instance, as a tool to give employees leeway in returning to work (in case of a perceived obligation to reciprocate) or as an instrument to push employees back to work quickly (no perceived need to reciprocate).

6.2 Practical contributions

Policies of activation

From an economic perspective, the adoption of the activation paradigm has brought about positive developments, when referring to yardsticks such as sickness absence and disability rates. Taking the Netherlands as an example, the sickness absence rate has decreased from 4.7 percent in 1996 – when the statutory wage payment period of one year in case of sickness absence was introduced as the first major activation measure –, to a stable average of about 4.2 percent in the period 2004-2011, and to 3.8 percent in 2014. Within Dutch hospitals, the sickness absence rate has declined from 6.3 to 4.4 percent over this time span (Statistics Netherlands, 2015a). At the same time, the enormous growth in the amount of disability beneficiaries since the 1970s – with a peak of almost one million in 2002 – has come to a hold (Van Gestel et al., 2013, p. 60; see also De Jong & Velema, 2010). In 2014, 820.000 citizens received a disability benefit (Statistics Netherlands, 2015c). Hence, from an economic point of view, activation policies may be considered efficient because they result in a decline of sickness absence and disability rates, and associated costs (although it must be noted that substitution effects have been shown to occur between benefits, and the unemployment rate has risen from 5.0 percent in 2011 to 7.4 percent in 2014; OECD, 2008; Statistics Netherlands, 2015d).

Despite these positive developments in the Netherlands, the inflow into the disability benefit has not followed suit, meaning that there is a stable number of around 38.000 sick-listed employees who annually leave the labor market via the disability pathway (UWV, 2015). This may point to the existence of a 'healthy worker effect' (see e.g., M. B. Nielsen & Knardahl, 2015), where the (more) healthy employees remain at work while the severely ill and disabled, who are unable to meet the demand for a quick return to work, leave the labor market. Indeed, it is questionable whether activation policies that were originally aimed at activating unemployed, *able*-bodied workers, can be used to determine a capacity for work in (temporarily) *disable*-bodied employees (Hetzler, 2009; MacEachen et al., 2007). After all, the activation paradigm stresses individual responsibility, which requires the empowerment of individuals in terms of a freedom to choose and the capacity to act (Betzelt & Bothfeld, 2011; Bonvin, 2008), of which the latter is problematic in case of (long-term) illness. My study included several instances where sick-listed employees (in both the Netherlands and Denmark) felt unable to return to work quickly, while their employers were convinced that these employees did not put in enough effort to return to the workplace. If sick-listed employees become excluded from employment because of their inability to meet these pressures to attend, we may ask whether the activation paradigm achieves its ultimate goal: an inclusive labor market.

Hence, there seems to be a need to rethink the division of individual and collective responsibilities within the activation policies that are directed at (long-term) sick-listed employees (Høgelund, 2003; Van Gestel et al., 2013). Building on the findings of my research, the return to work of these employees is likely to always be focused on its speed when the financial costs need to be borne by employers, who are simultaneously confronted with other (business) interests. The similarity of findings in the Netherlands and Denmark highlights that these costs do not only concern the statutory financial obligations, but also the indirect organizational costs associated with sickness absence (e.g., productivity loss, costs of replacement staff and of return-to-work support). At the moment, the activation paradigm therefore seems to be used mainly as a tool to deal with the issue of long-term sickness absence, helping employers to reduce costs, rather than to contribute to welfare goals. Based on these findings, it seems that reducing the direct as well as the indirect financial pressures, or – as one employee put it – 'taking finances out of the equation' may improve the return-to-work process. On the other hand, financial pressures have also been shown to incentivize employers to take actions regarding prevention and return to work (Cuelenaere & Veerman, 2011), which also showed in the comparison of return-to-work actions between the Dutch and Danish cases in Chapter 5. It thus seems essential to find an optimal balance between the responsibilities of employers and the government in sickness absence management, which might be located in between the Dutch and the Danish structure.

Put differently, my research suggests the possibility to reduce the financial responsibility of employers in the Netherlands, while maintaining their return-to-work responsibility, and to especially strengthen these latter responsibilities for employers in Denmark. A solution might be found by looking at the activation policies of other countries and, more specifically, to those of Germany. Although a detailed description of these policies is beyond the scope of this chapter (but see Verwer, Groothoff, Van der Velden & Van der Gulden, 2014, 2013), in the German policies, employers face a statutory wage payment period of six weeks, which is longer than in Denmark and shorter than in the Netherlands. Moreover, they are legally required to implement return-to-work actions (e.g., work adjustments, a gradual return, and vocational retraining) during 1.5 years, although they do not bear the costs of these actions. Instead, expenses are paid by German health insurance companies, the so-called 'Krankenkassen'. In other words, other than the statutory six-week wage payment period, most of the finances are 'taken out of the equation' for German employers (except for, for example, their social security contributions). What is more, the return-to-work process is guided by a 'Fallmanager' of the Krankenkasse, who is educated and experienced in this area, in contrast to line managers. In addition, the unique concentration of responsibilities for medical care, care for the return to work, and finances in one organization (the

Krankenkasse) allows for a better alignment between treatment and re-integration as well as for more independence towards organizations (Verwer et al., 2013, 2014). Although more research needs to be done into actual return-to-work processes in Germany, it is worthwhile to consider the design of the German activation policies, since both (long-term) sickness absence and disability rates have always been lower in Germany than in the Netherlands (Verwer et al., 2014).

The management of sickness absence

Although the hospitals in my study seemed mainly interested in sickness absence figures, my research calls into question the efficiency of this approach. It is not unlikely that the short-term focus on controlling sickness absence negatively affects the sustainability of the return to work and the employment relationship, potentially leading to turnover. For instance, Arends, Van der Klink, Van Rhenen, De Boer and Bültmann (2014) revealed how conflicts between supervisors and mentally sick-listed employees increase the risk of recurrent absence. Moreover, a focus on controlling absence figures may lead to 'presenteeism' (i.e. going to work while being ill, due to pressures to attend; Taylor et al., 2010). Both turnover and presenteeism appear to have a negative impact on organizational performance and service provision (Johns, 2010; Park & Shaw, 2013), and may thus lead to a lower quantity and quality of patient care, thereby impairing the hospitals' goals. Moreover, such a short-term focus does not lead to the prevention of health problems (Taylor et al., 2010; Van Gestel et al., 2015), although prevention becomes increasingly important due to the aging (working) population and changing lifestyles and working environments. Given the expected increase in chronic illnesses (e.g., cardiovascular diseases, cancer and diabetes), more and more people will have to combine work with care for their health (Van Gestel et al., 2013). Hence, focusing on controlling sickness absence, without paying attention to the (work and health) problems that caused the illness in the first place, might be more costly in the long term. Based on my study, I therefore argue for the relevance of looking beyond statistics and considering the process of, and the sick-listed employees' experiences with, returning to work. Below, I will make two recommendations to improve the management of sickness absence.

A first recommendation is to address existing perceptions and expectations in sickness absence management, in order to prevent the occurrence of disagreements between employers and employees that may impair the return-to-work process. As has been revealed in Chapter 4, managers' perceptions appear prompted by the behavior of sick-listed employees during past and present interactions (i.e. their loyalty to the workplace, sickness absence frequency, tenure, display of an active attitude to return to work, and transparency about (in)abilities to work). These

perceptions seem to affect how sickness absence is managed, and may hinder the return to work when managers' (negative) perceptions do not match those of sick-listed employees. Since raising awareness has been shown to be a precondition for change (Maon, Lindgreen & Swaen, 2009), workplace stakeholders (and managers in particular) first have to become aware of their perceptions and expectations, and possible consequences, in order to change how they deal with sickness absence.

Raising this awareness can be done by conducting 'focus groups' (Ivanoff & Hultberg, 2006) on sickness absence management and return to work, where the perceptions found in my research can be used as a starting-point for discussion. Once workplace stakeholders are aware of their perceptions and expectations, their behavior may be influenced in a way that either enhances objectivity in managing sickness absence (e.g., regarding managers: independent of the employee's past behavior), or encourages them to explicitly communicate and discuss expectations towards sick-listed employees (e.g., showing an active attitude and being transparent about medical conditions in relation to work) and towards managers (e.g., showing respect, taking the employee's interests into account). Concerning the latter, in Chapter 5, I have pointed out the importance of paying attention to communication skills, to ensure bidirectional dialogues between employers and employees as well as to improve ways of communicating ('it's the tone that makes the music'). Raising awareness among workplace stakeholders of their perceptions and expectations in sickness absence management and adequately acting upon these may thus be helpful to prevent disagreements on how to interpret and understand the behavior of employees. This may create a 'win-win situation' for all stakeholders involved: an early and sustainable return to work.

A second recommendation to improve sickness absence management relates to the 'devolution' of this practice from HR to line managers. The decentralization of responsibilities to local managers means that "many of the tensions between competing organizational priorities are played out at this level" (Cunningham et al., 2004, p. 274). As we have seen in the previous chapters, having to combine business and wellbeing interests leads managers to incorporate the activation paradigm in their striving for cost reduction (through selective coupling), which is not necessarily in the best interests of sick-listed employees when they feel pushed back to work. It may thus be questioned whether the advantages of devolving sickness absence management to line managers (e.g., their greater familiarity with the work, the workplace and the employee, due to their closer proximity) outweigh its disadvantages, at least in case of long-term sickness absence (see also Renwick, 2003a, 2003b). According to Renwick (2003b), "[l]ine manager involvement in HRM raises the issue of whether employees trust the motives of line managers to look after their wellbeing" (p. 276). Being caught between competing interests makes it difficult, if not impossible, for managers to solely act in accordance with the employees' interests.

My study reveals that what seems to be missing is a support for the sick-listed employee, or at least a neutral third party. As I have shown in Chapter 5, this may be resolved in Denmark by including the union representative or municipality councilor to support the employee from the start of each (long-term) sickness absence. In the Netherlands, several actors could focus on providing employee support or act as a neutral party, provided that the current organization of their roles is somewhat altered or extended. For instance, Dutch (confederations of) trade unions and municipalities, which nowadays either represent employees at the national and sector level or have no statutory role in sickness absence management, could be given a (stronger) role in individual return-to-work processes. Likewise, the function of works councils may be extended from being employee representatives at the organizational level to being a support for individual sick-listed employees as well. Another possibility can be found in the role of occupational health physicians, if they are enabled to take on a more supporting or independent position, for example, by extending their contracts and reducing their workload and financial dependence (Plomp & El Markhous, 2015). Finally, strategic HR policies could be installed that specifically advance the interests of employees, ensuring that HR managers can act as 'guardians of employee wellbeing' (Renwick, 2003a) next to being what the HR managers in my study called 'consultants on the rules for line managers'. Hence, with some changes, several options seem to exist to include a support for sick-listed employees or a neutral third party in return-to-work processes in the Netherlands.

6.3 Methodological reflection and suggestions for future research

As shown above, I believe that my dissertation has provided a better theoretical understanding of the ways in which the microfoundations of an institutional logic can be understood, as well as a better practical insight into the microfoundations of the activation paradigm. However, as with all research, my study also has several limitations. In this section, I will reflect on the design of my research and the choice for interviews, and I will outline the limitations that constrain the scope of my findings. Finally, I will relate these limitations to suggestions for future research.

Research design and data collection method

In this dissertation, applying a multiple-case study design and conducting interviews were considered appropriate to compare how the activation paradigm is translated into the actual management of sickness absence in the four hospitals across the Netherlands and Denmark. As Zilber (2008) described: "Meanings [as in translation]

elude quantification, do not allow for causal inferences and explanations in the form of correlations between clear causes and effects. Instead, meanings call for 'after the fact' interpretations, and for case studies with thick accounts rather than broad generalizations" (p. 154). Data were gathered via expert interviews on the macro level and topic interviews on the micro level, which were preceded by a document study on the macro and meso level. The richness of information provided by this data collection method was enhanced by interviewing multiple stakeholders in each country (macro level) and in each sickness absence case (micro level). This approach enabled a unique multi-angled perspective on the same phenomenon, including from different hierarchical positions (e.g., employees and managers) and from various functional areas (e.g., government, management, occupational health, and unions). From a methodological viewpoint, interviewing multiple stakeholders decreased the probability of social desirability and memory biases, since "[a] key approach [to mitigating these biases] is using numerous and highly knowledgeable informants who view the focal phenomena from diverse perspectives" (Eisenhardt & Graebner, 2007, p. 28). Moreover, at the micro level, all employees were (partly) absent or had only returned to work up to two weeks before the interview, so that the interviewees still had a fresh memory of the return-to-work process.

Of course, the management of sickness absence and return to work could have been studied with other data collection methods as well. For instance, (longitudinal) questionnaires are helpful to determine causes and effects (e.g., the impact of 'problematic' cases on the sustainability of the return to work and on the future employment relationship), while observations enable a more detailed "*in situ* and *in vivo*" understanding of what actors actually do in practice (Zilber, 2008, p. 164; italics in original; Langley & Abdallah, 2011). Although I believe that questionnaires or observations can be worthwhile in these respects, they could not have given the insights that I obtained by means of interviews. Taking Chapter 4 on the importance of social interactions in the translation process as an example, it is precisely through the reflections of the managers on (the role of) their sick-listed employees *and* the perspectives of the employees, that a recurring pattern was found in how managers evaluated their employees and decided whether or not to reciprocate. It would have been impossible to measure or observe that managers evaluated their employees as, for instance, (in)active, (non-)transparent or a good/bad employee, since they never seemed to communicate these criteria directly with their employees (managers themselves might not even be aware of their use of these criteria). I therefore believe that the interviews have enabled a good insight into the (perceptions of) social interactions between managers and employees, particularly because both managers and employees were interviewed, enabling a two-sided view on the social interaction (and even a multi-angled perspective; see Chapters 3 and 5).

Generalizability of findings

A boundary condition of my dissertation relates to the research setting. As became particularly salient in Chapter 3, hospitals present a special case regarding the translation of the activation paradigm in sickness absence management, due to the medical knowledge available within the healthcare sector. Hospital actors, and managers in particular, experienced difficulties with the 'demedicalization' of sickness absence that is central to the activation paradigm, since it collides with daily medical practices that are focused on treating illnesses. Moreover, hospitals are large organizations that are more often confronted with sickness absence and have more (financial and human) resources to address this issue than small- and medium-sized organizations. The peculiarities of the healthcare sector and the hospitals' size may limit the generalizability of my findings to other settings. On the other hand, it is unlikely that the 'balancing act' between business and social interests (see Chapter 3) is specific to hospitals, since all (public as well as private) organizations are subject to the same national activation policies. The pressures of these national policies to take care of sick-listed employees have to be balanced with production or service requirements in these organizations, too.

To increase the generalizability of my findings, future research could extend my study by including non-medical organizations, particularly those in the for-profit sector. It would be worthwhile to investigate whether the push for a quick return to work is even stronger in these companies, given the need to make profits, or maybe less so because people might have more autonomy regarding how, when and where to perform their jobs and thus have more options to 'choose their absence' (e.g., by being able to work from home when not feeling well, or to retreat in one's own office). For instance, in their study of law firms, Van Gestel and Nyberg (2009) showed how lawyers could postpone being absent for a longer time than secretaries, resulting in suspicion concerning the credibility of the secretaries' illnesses and a focus on controlling their short-term sickness absence rather than the long-term absence of lawyers. In their examination of call centers, Taylor, Baldry, Bain and Ellis (2003) demonstrated how managers' experiences of strong pressures to achieve call volumes led them to prioritize business interests over the wellbeing of employees, and employees – in their turn – felt pressured to return to work.

Moreover, after having compared the presence of the activation paradigm in the Dutch, Danish and Irish national sickness absence policies in Chapter 2, in the subsequent chapters, I focused on the Netherlands and Denmark, being forerunners regarding the adoption of this paradigm at the macro level. Including these two countries enabled examining the translation of the activation paradigm into the management of sickness absence at the micro level. However, to better discern the actual impact of the activation paradigm, future research could investigate sickness

absence management in countries that have not implemented this paradigm to the extent that the Netherlands and Denmark have, and compare their findings to mine. This would further improve our understanding of the relationship between national legislation and local actions, especially in relation to activation policies (Tiedtke et al., 2012; Van Raak et al., 2005).

Microfoundations as a top-down and bottom-up focus

As explained in Chapter 1, in my dissertation, the microfoundations of institutional logics were defined as a top-down focus, since I was especially interested in knowing how the activation paradigm is translated into local sickness absence practices. This enabled studying how "actors interpret institutional logics so they fit the local context" (Waldorff, 2013, p. 220), instead of the often-covered ground of the diffusion of logics at the field or industry level without offering an insight into what happens in practice (Lindberg, 2014; Lounsbury & Boxenbaum, 2013). However, in their definition of microfoundations, Powell and Colyvas (2008) also distinguished a bottom-up focus, where micro-level (inter)actions "ratchet upwards" to change or disrupt macro-orders (p. 278). While I have thus specifically addressed the 'action' phase of the translation process, future research could apply a micro-to-macro perspective to obtain an in-depth understanding of the 'institution' phase (Czarniawska & Joerges, 1996), during which institutionalization may or may not occur. Such an approach would provide a more complete insight into the microfoundations of an institutional logic as well as of the translation process.

By the end of my PhD trajectory, understanding whether micro-level actions affect the activation paradigm at the macro level appears particularly interesting in the Netherlands, given a recent decision of the Rutte-Asscher cabinet to reduce the statutory financial obligations of employers with 10 or less employees from two to one year (which at the moment of writing still needs to be approved by the Dutch parliament).[6] This decision is a response to the problems in small-sized enterprises, which are reluctant to hire employees on a permanent basis due to the long wage payment period in case of sickness absence, and thereby contribute to the increasing amount of people working in precarious jobs (for an elaboration of this issue, see Van Gestel et al., 2013). By decreasing the financial obligations of small employers to one year, the cabinet assumes that the abovementioned issue will be addressed to a large extent, since many businesses in the Netherlands employ up to 10 employees (more than 95 percent, Statistics Netherlands, 2015e). Given this

6 Decision of October 2, 2015. See http://fd.nl/economie-politiek/1121287/loondoorbetalingplicht-bij-ziekte-wordt-beperkt-voor-kleine-ondernemers, last retrieved December 29, 2015

cabinet decision, it seems that micro-level actions are bubbling up to change the national institutional context; nonetheless, future research should examine whether and how they actually do so.

The acceptance of an idea in the translation process

Finally, my research specifically focused on the translation of the activation paradigm at the hospitals' frontline, after its acceptance at the organizational level (the latter being studied by means of the sickness absence policies of the hospitals, as described in Chapter 3). In doing so, I have been able to study the "less powerful members of organizations", who are often overlooked in both institutional and translation studies (Powell & Colyvas, 2008, p. 277; see also Ansari, et al., 2010; Helin & Sandström, 2010; Reay et al., 2013; Rocha & Granerud, 2011). Nevertheless, this focus on frontline actions has come at the cost of examining how an idea such as the activation paradigm arrives at organizations in the first place. It would therefore be worthwhile to also study the 'idea' and 'object' phase of the translation process (Czarniawska & Joerges, 1996), during which the idea of the activation paradigm is selected and framed as *the* solution for the problems of sickness absence, and turned into an object. In this regard, examining translation practices in combination with 'theorization' practices, which involve specifying a problem and a solution and justifying that solution (Greenwood et al., 2002) seems fruitful to better understand the translation process as well as actors' responses to institutional logics (see also J. A. Nielsen, Mathiassen & Newell, 2014).

Studying the 'idea' and 'object' phases of the translation process is particularly intriguing in the Dutch hospitals, where consultants were hired to implement the activation paradigm (see Section 1.3 and Chapter 3). As Czarniawska and Joerges (1996) wrote, professional consultants are important carriers of ideas: "Like travelling salesmen, they arrive at organizations and open their attaché-cases full of quasi-objects to be translated into localized ideas. [...] They are designers and distributors, wholesalers and retailers in ideas-turned-into-things, which then locally once more can be turned into ideas-to-be-enacted" (p. 36). In the Dutch hospitals, the consultants have objectified the activation paradigm by labeling it as a slogan ('Sickness happens, absence is a choice'), which has also been travelling to other parts of the Netherlands (Roeters, 2005). Future research could examine how the consultants persuaded the hospitals' top management of this slogan and of the associated approach to combat sickness absence, or how they do so in different hospitals or other organizations. From a translation perspective, one would ask to which 'master-idea' (Czarniawska & Joerges, 1996) the slogan relates that makes it so appealing to translate (e.g., liberalism in the sense of individual responsibilities)? And, more importantly, how does it affect the spread of the activation paradigm?

6.4 Conclusion

Looking back on my journey to the microfoundations of the activation paradigm, a picture that sticks to mind is one in which intra-organizational actors need to cope with an institutional logic that is open to multiple interpretations (i.e. as a focus on the wellbeing of the sick-listed employee or on cost reduction), which are not necessarily compatible. In dealing with this 'intra-logic complexity', local actors selectively couple the activation paradigm to their sickness absence practices, in a way that aligns mainly with the focus on cost reduction (by 'cherry-picking'). That is, rather than considering the employees' possibilities, the activation paradigm is translated locally as a focus on the speed of the return to work, 'propelling' employees back into work. However, underneath this picture we found that managers' translation of the activation paradigm (either as a focus on wellbeing or on cost reduction) strongly depends on their positive or negative perception of both past and present social exchanges with their employees, as well as on the cause of the illness (physical or mental) and the (expected) absence duration. As a result, managing sickness absence has become a subjective endeavor, which on the short term does not seem to contribute to the aim of the activation paradigm to promote the wellbeing of all sick-listed employees, and on the long term potentially conflicts with the aims of cost reduction of both the government and organizations.

At the end of my travel to the microfoundations of an institutional logic, I believe that my dissertation has also added some luggage for future research. Most importantly, my research has shown the relevance of making pit stops at different levels of analysis (macro, meso and micro) when traveling to the microfoundations of an institutional logic, and especially to take a look at the (inter)actions occurring at the frontline or micro level. In this way, institutional complexity may not only reveal between different institutional logics, but also within a single logic.

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APPENDICES

Appendix A:
Interview guide – expert interviews

Appendix B:
Topic list and interview guide – hospitals

Appendix A

Interview guide – expert interviews

1	**Background information**
	What is your job? How are you involved in the national policies of sickness absence?
2	**Underlying idea of activation in sickness absence policies**
	How have the national sickness absence policies evolved over the last couple of years? Have there been changes to existing laws, or have new laws been introduced?
	Has the idea of activation been introduced in the national sickness absence policies? Why (not)? How does that show?
	Do you think that employers and employees have adopted the idea of activation in relation to sickness absence? Why (not)? If so, how does that show in how employers manage sickness absence?
	Do you agree with this 'activation' view of illness? Why (not)?
3	**Responsibilities & routines**
	The activation paradigm aims to decrease the number of sickness (and disability) beneficiaries. In your opinion, who is responsible for decreasing this amount?
	At the moment, who is responsible for paying the wages of sick-listed employees?
	At the moment, who is responsible for the return to work of sick-listed employees?
	Would/do employers accept an increased role in sickness absence management, e.g., in the return-to-work process? Why (not)?
	In your opinion, what effect will an increased role have on how employers manage sickness absence?
4	**Regulations**
	In the literature on policy instruments a distinction is made between regulations, economic means and moral persuasion. How would you characterize the national approach towards making employers active in sickness absence management, choosing from these three instruments (you can choose more than one instrument)? Why do you think that the government has chosen this approach?
	Are you satisfied with the current national sickness absence policies? Why (not)? What would you change?
5	**International/eu level**
	To what extent do you think that the national policies of sickness absence are influenced by policies of other countries or by the eu?

N.B. Although questions were introduced and framed according to the situation in each of the three countries, I ensured that the abovementioned questions were addressed in each interview.

Appendix B

Topic list and interview guide – hospitals

Background information	
Job	What is your job within the hospital? What are your primary tasks?
Work history	Can you tell me about your work history?
Description of the sickness absence case	
Cause(s)	What do you think is the cause of the sickness absence in this case? How long are you/is the employee in this case absent?
Relationship with work	Is the sickness absence related to the job and/or the organization? If so, how? If so, do you think the sickness absence could have been prevented?
Solution(s)	Which solutions do you see for this sickness absence case? Who has to do what according to this solution? (employee, manager, others)
Actors and their role in sickness absence management	
Own role	What is your own role in sickness absence management? How do you feel about your role? What are your reasons for (dis)satisfaction?
Role of others	Which other actors are involved in this sickness absence case? What is the role of these actors? How do you feel about their role? Do they take their responsibilities? How does that show?
Collaboration between actors	
Interaction	How do the actors collaborate in this sickness absence case? Are you satisfied about the collaboration? If not, why? What do you suggest to improve collaboration?
Actions	
Actions	What actions are taken in this case? How do you feel about these actions? Do these actions actually work? Are they sufficient?
Sanctions	Are sanctions used in this sickness absence case? What are the sanctions that can be used in sickness absence management?
Representativeness	Is this case representative for the way in which sickness absence is managed within the hospital? If not, what is specific? How does sickness absence management work in other cases? What are the differences?
Policy	What is your opinion about the sickness absence policy of the hospital? What are your reasons for (dis)satisfaction?

English summary
Nederlandse samenvatting
Dankwoord
About the author

English summary

Since the 1990s, a new view on what constitutes appropriate sickness absence behavior has emerged in the welfare states of many European countries. While '(bed) rest' has traditionally been seen as the best way to recover from an illness (during which one receives a sickness benefit), today, the idea is that sickness and work are not mutually exclusive, and that continuing work while being ill may even have a positive influence on a full return to work. A sick-listed employee is thus expected to return to the workplace as soon as possible, albeit with adjusted work tasks and/or working hours. Consequently, the focus is no longer on the *disabilities* of sick-listed employees, but on their remaining *ability* to work (Hetzler, 2009). This new view on appropriate sickness absence behavior constitutes the 'activation paradigm' and fits with the aim of European governments to protect and increase labor market participation, in order to secure the economic self-reliance of individuals as well as the long-term viability of the welfare state (Bonvin, 2008; Eichhorst et al., 2008; Weishaupt, 2011).

Although by now the activation paradigm is regarded as a politically legitimate and appealing discourse (Bothfeld & Betzelt, 2011; Eichhorst et al., 2008; Weishaupt, 2011), so far, relatively little is known of how this paradigm is implemented in actual sickness absence practices within organizations (OECD, 2010; Seing et al., 2014; Tjulin et al., 2010). This is remarkable, since the introduction of the activation paradigm has led to an increased role for employers in ensuring the early return to work of sick-listed employees, by adjusting work tasks and/or working hours (e.g., OECD, 2010, 2015). Given this lack of knowledge, the aim of my dissertation is to increase our insights of the processes through which the activation paradigm is translated into organizational practices, specifically in the area of long-term sickness absence (i.e. absence for six weeks or longer). These processes are what I call the 'microfoundations' of the activation paradigm: the intra-organizational processes through which macro-ideas, like the activation paradigm, "are 'pulled down' and become imbricated in local or particular cases" (Powell & Colyvas, 2008, p. 278; Thornton & Ocasio, 2008). The main research question of my dissertation therefore is as follows: *What are the microfoundations of the activation paradigm in sickness absence management, within organizations (hospitals) in the Netherlands and Denmark?*

An answer to this research question is provided by addressing four sub-questions, which are addressed in the individual chapters of my dissertation:

1 How is the activation logic understood and given shape in the national sickness absence policies in the Netherlands, Denmark and Ireland, in terms of underlying ideas and governance systems? (Chapter 2)

2 How are national activation policies re-contextualized, re-labeled and defined into actions within organizational policies of sickness absence, and in daily sickness absence practices at the frontline? (Chapter 3)

3 What role do social interactions play in the translation of macro-ideas (such as the activation paradigm) into micro-level practices (like in sickness absence management)? (Chapter 4)

4 How and why do the return-to-work experiences of various workplace stakeholders differ between physical and mental health conditions, and what are the consequences of potentially different experiences for the return-to-work process in both health conditions? (Chapter 5)

To address these questions, I apply 'institutional theory', which aims to explain how institutional demands – or society's expectations of appropriate behavior – affect the actions of organizations and individuals (Dacin, 1997; Scott, 2008). These demands consist of "rules and regulations, normative prescriptions and social expectations" (Pache & Santos, 2010, p. 457), as well as of cultural templates or 'institutional logics': explicit and implicit rules of appropriate (inter)action and interpretation that are provided by 'institutional orders', such as the state, the market, the family, religion and professions (Pache & Santos, 2010; Thornton & Ocasio, 1999). The activation paradigm can be considered an institutional logic, as argued in Chapter 2.

In my dissertation, I use a distinctive approach within institutional theory: 'Scandinavian institutionalism' (Czarniawska & Sevón, 1996, 2003) and its concept of 'translation' in particular (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996). In contrast to the macro-oriented institutional theory, the translation approach "offers both a conceptual and methodological way forward" in understanding the process through which institutional logics are translated within organizations (Lawrence & Sudday, 2006, p. 243). 'Translation' here entails "the more or less deliberate transformation of practices and/or ideas that happens when various actors try to transfer and implement them" (Røvik, 2011, p. 642). The goal of my dissertation is to contribute to the translation approach by explicitly considering translation processes at the micro level, or the actions of and interactions between individuals. One way I aim to do so is by combining the translation approach with 'social exchange theory' (Blau, 1964), which seeks to understand workplace behavior by examining interpersonal interactions within organizations (Cropanzano & Mitchell, 2005; Di Domenico et al., 2009).

Research context

My research is conducted in the Netherlands, Denmark and (initially) Ireland.[7] The choice for these countries is based on their comparable sickness absence figures, and hence their equal challenge of reducing recourse to sickness (and disability) benefits (OECD, 2008). In addition, their reputation as 'employment miracles' regarding their approach to combat unemployment (Auer, 2002; Schwartz & Becker, 2005; Torfing, 1999) led to the assumption that the three countries have implemented the activation paradigm in the area of sickness absence as well. Another reason for selecting the Netherlands, Denmark and Ireland is the difference in the division of responsibilities between the government and employers in their national sickness absence policies: while the Dutch policies emphasize the (financial) efforts of employers in sickness absence management, the Irish policies stress the efforts of the central government. Denmark takes a middle position, since local governments are mainly responsible but employers are increasingly given a role as well. It is interesting to examine whether these differences lead to variation in the management of sickness absence within organizations.

Furthermore, my research specifically focuses on the healthcare sector, since managing sickness absence is particularly urgent here and, hence, this sector provides a relevant research context. For instance, on average, the healthcare sector faces higher sickness absence rates than other industries (in 2013, the sickness absence rate across the Netherlands and Denmark was 3.9 and 3.8 percent, respectively, against 4.8 and 6.1 percent in healthcare in the two countries; Statistics Netherlands, 2015a; Statistics Denmark, 2015b). Furthermore, the healthcare sector is increasingly confronted with employee shortages, which is amplified by the aging of the (working) population (Buchan & Aiken, 2008). These issues reveal the importance for healthcare organizations to retain their employees and to prevent sickness absence. Within the healthcare sector, I focused on hospitals (two in each country), because these organizations are internationally comparable and are large enough to select sufficient cases of long-term sickness absence without violating the anonymity and privacy of individual participants.

Data have been collected in two studies. The first study entails a multiple-case study of the sickness absence policies of the Netherlands, Denmark and Ireland at the national level, and includes a literature review and 18 interviews with experts in the field of sickness absence, return to work, working conditions or social security

7 As Chapter 2 shows, the activation paradigm is largely absent in the Irish national sickness absence policies. This meant that Ireland no longer presented an appropriate case for studying the microfoundations of the activation paradigm. I therefore decided to drop Ireland from further research and to focus on the Netherlands and Denmark.

in general (i.e. government officials, representatives of employers' associations and unions, and researchers). This study is central to Chapter 2 of my dissertation. The second study concerns a multiple-case study of sickness absence management within two Dutch and two Danish hospitals, and includes an examination of the hospitals' sickness absence policies and interviews with the actors involved in 21 cases of long-term sickness absence (61 interviews in total, with sick-listed employees, managers and – depending on the country and the hospital – with Human Resource (HR) managers, union representatives, occupational health physicians, and other work and health professionals. Chapters 3 to 5 are based on this study.

Findings

Chapter 2 demonstrates how the activation paradigm is given shape in the *national* sickness absence policies in the Netherlands, Denmark and Ireland, as the necessary first step in understanding the microfoundations of this paradigm. In this chapter, I approach the activation paradigm as an institutional logic that consists of (1) underlying ideas about the problem of sickness absence and about how and by whom this problem needs to be solved, and (2) a governance system that defines responsibilities, routines and regulative instruments for putting these ideas into practice. Although the Netherlands and Denmark have adopted the underlying ideas of the activation paradigm, Ireland has not (leading me to exclude this latter country from further study, see footnote). Despite their similarity in underlying ideas, the Dutch and Danish national policies differ in their governance systems: while Dutch employers carry the financial and return-to-work responsibilities during the first two years (without the possibility to dismiss and with strict legislation and sanctions), Danish employers are financially responsible for 30 days and carry part of the return-to-work responsibility (with the possibility to dismiss and without sanctions), since municipalities are mainly responsible in Denmark. These different governance systems could result in different sickness absence practices, which is studied in the subsequent chapters and is explicitly addressed in Chapters 5 and 6.

Chapters 3, 4 and 5 zoom in on the meso (organizational) and micro level, and show how the activation paradigm can be interpreted as a focus on the wellbeing of the employee or on cost reduction, two interpretations that are not necessarily compatible. In dealing with this situation of complexity, **Chapter 3** demonstrates how individual actors translate only those components of the activation paradigm that are most desirable or suitable to achieve their interests. I call this 'cherry-picking', or the 'selective coupling' of the activation paradigm to local sickness absence practices. This reveals in my finding that the emphasis of the activation paradigm on an early return to work (i.e. before full recovery) is used in many

cases to push sick-listed employees to return to work as *soon* as possible, even if this is not *possible* according to the employee. This push for a quick return to work seems to be caused by disconnecting sickness from the need to be absent in the hospitals' sickness absence policies (e.g., in the slogan 'sickness happens, absence is a choice'). Hence, it seems that returning to work 'as *soon* as possible' is preferred over returning to work 'as soon as *possible*', where the possibilities of the employee are taken into account first. With the focus on the speed of the return to work, the activation paradigm seems mainly translated as a way to reduce costs.

Chapters 4 and 5 nuance this conclusion: whether the activation paradigm is translated as a focus on the wellbeing of the employee or on cost reduction appears to depend on the managers' positive or negative perception of the social interaction with their employees in the past and the present (Chapter 4), as well as on the cause of the absence (physical or mental) and the expected absence duration (Chapter 5). By examining the translation of the activation paradigm from a 'social exchange perspective', **Chapter 4** reveals that the push for a quick return to work (and hence, the focus on cost reduction) depends on managers' perceptions of the social interaction with sick-listed employees. These perceptions are based on one or more of the following criteria: the value of the employee to the organization (loyalty), his or her tenure and sickness absence frequency (all related to the past), the employee's active attitude to return to work and his or her transparency about medical (im)possibilities in relation to work (related to the present). The push for a quick return to work then appears primarily present in cases where the manager has a negative perception of the social exchange with the employee, which results in a strict translation of the activation paradigm and its rules and regulations, without explicit consideration of the needs of the sick-listed employee. In these cases, the return-to-work process proceeds problematically, since disagreements occur between managers and employees regarding the timing and pace of the return to work. By contrast, employees who are perceived positively by their manager are given more time and room to return to the workplace, resulting from a flexible translation of the activation paradigm. However, it should be noted that these employees already express an active attitude to return to work quickly.

Chapter 5 compares the return-to-work experiences of the various actors between physical and mental cases. This chapter shows how the push for an early return to work especially occurs in mental cases; in physical cases only when the return to work takes longer than the expected duration. In the Dutch hospitals, this push especially reveals during the analysis of the employee's remaining work capacity by the occupational health physician, who (in the eyes of the employee) decides too quickly that the employee is able to return to work, without acknowledging his or her health complaints. In the Danish hospitals, the focus on a quick return to work occurs in both mental and physical cases, when no return-to-work plan is made,

when the plan does not match the employee's needs or when the plan is not held on to. Again, in these cases, disagreements occur between managers and employees regarding the timing and pace of the return to work. From both countries lessons can be drawn: the Danish cases reveal that the focus on a quick return to work can be prevented by including a union representative or a municipality councilor as a support for the sick-listed employee, while the Dutch cases demonstrate that the return-to-work plan (regardless of the absence cause) is an important guidance for the employee, provided that the needs and possibilities of the employee are taken into account. Despite the existence of different perceptions of physical and mental health complaints, this chapter shows the relevance of an equal dialogue about an employee's remaining work capacity as well as the importance of a return-to-work plan, irrespective of the illness.

In sum, my dissertation reveals the centrality of the *speed* of the return to work in the translation of the activation paradigm within organizations, but it also shows that sickness absence management is a subjective endeavor, where perceptions of the behavior of others (here: sick-listed employees) and expectations of the (duration of) illnesses affect how absence is dealt with. Contrary to my expectations that the differences between the Netherlands and Denmark (in terms of roles and responsibilities of employers) would lead to variety in sickness absence management, my findings were highly similar between both countries. This might indicate that the local context has a greater influence than macro-ideas (such as the activation paradigm), but also that the Netherlands and Denmark might not be so different after all: both countries are "smaller, highly developed north-western European countries with a similar culture of tolerance and flexibility and with a strong commitment to social citizenship rights" (Van Oorschot & Abrahamson, 2003, p. 289). However, the similarity of findings may also reveal the equal impact of the strict and detailed legislation (with sanctions) in the Netherlands and the normative legislation (without sanctions, but with moral persuasion) in Denmark on local behavior (see e.g., Vasudeva, 2013).

Theoretical contributions

My dissertation contributes to (Scandinavian) institutional theory and the translation approach in three ways. First, my research underscores the importance of taking a multi-level approach in institutional theory, and particular in the study of institutional logics (Battilana, 2006; Reay et al., 2013; Van Gestel & Hillebrand, 2011). By considering macro, meso and micro levels of analysis, I show that logics do not exist by themselves, but that "it is only when the logics are enacted that they become part of practice" (Lindberg, 2014, p. 496). However, by taking a translation

perspective, I demonstrate that in becoming part of practice, the meaning of a logic changes in a way that diverges from its macro-level formulation. This particularly appeared to occur during actions and interactions at the micro level (e.g., through 'selective coupling'). My study herewith points to the importance of examining micro-level (inter)actions to understand the microfoundations of an institutional logic, and shows how the translation approach provides a fruitful starting-point for doing so.

A second contribution of my dissertation relates to the definition of institutional complexity, or the situation in which actors face "incompatible prescriptions from multiple institutional logics" (Greenwood et al., 2011, p. 318). My research shows that institutional complexity may not only occur when two or more logics are at play, but may also occur within a *single* logic, when the prescriptions of an institutional logic are subject to multiple interpretations, and these different interpretations are perceived as difficult to reconcile. The activation paradigm appears interpretable as a focus on the wellbeing of the employee and as a focus on cost reduction. These foci are not necessarily compatible, since local actors seem to perceive these foci as prescribing incompatible behaviors: 'spending' time and efforts in promoting the wellbeing of the sick-listed employee versus 'saving'. As my study shows, this situation of 'intra-logic complexity' may result in different local practices. While others have called for a better definition of 'incompatibility' (Greenwood et al., 2011; Smets & Jarzabkowski, 2013) as well as of 'institutional' logics (R. E. Meyer & Höllerer, 2014), to the best of my knowledge the issue of complexity within logics has not been addressed to date.

Finally, my dissertation adds new insights into *how* and *why* individuals (in contrast to 'organizations') respond to institutional logics (McPherson & Sauder, 2013; Pache & Santos, 2013a; Thornton et al., 2012). My research shows that individuals may respond to an institutional logic through the 'selective coupling' of this logic to their daily practices, by only selecting its most desirable or suitable elements (e.g., by 'cherry-picking' the activation paradigm's focus on returning to work before full recovery). In this way, individual actors conform to the prescriptions of an institutional logic (unlike in the case of 'decoupling', J. W. Meyer & Rowan, 1977), yet in a way that serves their own interests. Furthermore, my study provides a better understanding of the motivations to respond to an institutional logic: while (Scandinavian) institutional theory traditionally assumes that behavior follows a logic of appropriateness (March & Olsen, 2006), I show that the motivation to act appropriately depends on the presence of a 'norm of reciprocity', which – in its turn – is based on the appropriateness of the behavior of the other (e.g., the manager who seems to adjust his or her behavior to the actions of the employee). In other words, it seems that an individual only behaves appropriately when the other does (or has done) so as well. I call this a 'quid-pro-quo mechanism'.

Societal contributions

Policy implications

Despite the decline of national sickness absence rates (e.g., in the Netherlands from 4.7 percent in 1996, to a stable average of about 4.2 percent in the period 2004-2011, and to 3.8 percent in 2014), many sick-listed employees still leave the labor market via the disability pathway (38.000 people annually in the Netherlands; UWV, 2015). This may point to the existence of a 'healthy worker effect', where the (more) healthy employees remain at work while the severely ill and disabled, who are unable to meet the demand for a *quick* return to work, leave the labor market. In this way, the current policy in the Netherlands and Denmark does not seem to lead to an inclusive labor market.

Building on the findings of my research, the return to work of sick-listed employees is likely to always be focused on its speed when the financial costs need to be borne by employers, who are simultaneously confronted with other (business) interests. The similarity of findings in the Netherlands and Denmark highlights that these costs not only concern the statutory financial obligations, but also the indirect organizational costs associated with sickness absence (e.g., productivity loss, costs of replacement staff and of return-to-work support). It thus seems recommendable to reduce the sickness absence costs for employers, although a certain amount of financial incentives is required to motivate employers to take actions regarding prevention and return to work (see Chapter 5; Cuelenaere & Veerman, 2011).

The optimal division of sickness absence responsibilities thus seems to be located in between the situation in the Netherlands and Denmark, and implies a reduction of the financial responsibility of Dutch employers, while maintaining their return-to-work responsibility, and an increase of especially the latter responsibility for Danish employers. A solution might be found by again considering the activation policies of other countries and, more specifically, those of Germany. Although a detailed description is beyond the scope of my dissertation, in the German policies, employers face a statutory wage payment period of six weeks (i.e. longer than in Denmark and shorter than in the Netherlands), while they are legally required to implement return-to-work actions during 1.5 years. However, the costs of these actions are borne by health insurance companies (the so-called 'Krankenkassen') and the return-to-work process is guided by an experienced 'Fallmanager' (Verwer et al., 2013, 2014). Given the lower sickness absence and disability rates in Germany as compared to the Netherlands (Verwer et al., 2014), future research could examine return-to-work processes within German organizations, to determine whether the German policies provide a suitable solution for the division of responsibilities between employers and government in the Netherlands and Denmark.

Implications for organizations

My research calls into question the focus of the hospitals in my study on sickness absence figures and a quick return to work. It is not unlikely that the disagreements that occurred in some cases negatively affect the sustainability of the return to work and the employment relationship, potentially leading to turnover. For instance, Arends et al. (2014) revealed how conflicts between supervisors and mentally sick-listed employees increase the risk of recurrent absence. Moreover, a focus on controlling absence figures may result in employees going to work while being ill, due to pressures to attend ('presenteeism'; Taylor et al., 2010). Both turnover and presenteeism appear to have a negative impact on organizational performance and service provision (Johns, 2010; Park & Shaw, 2013). Moreover, such a short-term focus does not lead to the prevention of health problems (Taylor et al., 2010; Van Gestel et al., 2015), although prevention becomes increasingly important due to the aging (working) population and changing lifestyles and working environments. Given the expected increase in chronic illnesses (e.g., cardiovascular diseases, cancer and diabetes), more and more people will have to combine work with care for their health (Van Gestel et al., 2013). Hence, focusing on controlling sickness absence, without paying attention to the (work and health) problems that caused the illness in the first place, might be a more costly strategy in the long term.

My dissertation provides two recommendations to improve the management of sickness absence. First, it shows the importance of addressing existing perceptions and expectations in sickness absence management, in order to prevent the occurrence of disagreements between employers and employees that may impair the return-to-work process. Change starts with raising awareness (Maon et al., 2009) among workplace stakeholders (and managers in particular) of their perceptions and expectations, and possible consequences. Raising awareness can be achieved by conducting 'focus groups' (Ivanoff & Hultberg, 2006), where managers' perceptions of sick-listed employees that revealed during my research may be used as a starting-point for discussion (see Chapter 4: loyalty, sickness absence frequency, tenure, an active attitude to return to work, and transparency about (in)abilities in relation to work). Once workplace actors are aware of their perceptions and expectations, their behavior may be influenced in a way that either enhances their objectivity in managing sickness absence (e.g., regarding managers: independent of the employee's past behavior), or encourages them to explicitly communicate and discuss expectations towards sick-listed employees (e.g., showing an active attitude and being transparent about medical conditions in relation to work) and towards managers (e.g., showing respect, taking the employee's interests into account). To do so, good communication skills are utterly important (see Chapter 5).

A second recommendation relates to the 'devolution' of the practice of sickness

absence management from HR to line managers. Despite the advantages of devolving this task to line managers (e.g., their greater familiarity with the work, the workplace and the employee, due to their closer proximity), they are faced with seemingly conflicting interests: the care for the sick-listed employee and for the organization. My study has shown how these conflicting interests result in a focus on returning to work as *soon* as possible, which mainly seems to benefit the organization (on the short term). A solution for this dilemma could be to include a support for the sick-listed employee, or to search for a neutral third party. This can be readily achieved in Denmark by including the union representative or municipality councilor at the start of each (long-term) sickness absence case (see Chapter 5). However, in the Netherlands, several actors could focus on providing employee support or act as a neutral party, provided that the current organization of their roles is somewhat altered or extended. For instance, Dutch trade unions, works councils and municipalities, which nowadays either represent employees at the national/sector level or at the organizational level, or have no statutory role in sickness absence management, could be given a (stronger) role in individual return-to-work processes. Another possibility can be found in the role of occupational health physicians, if they are enabled to take on a more supporting or independent position, for example, by extending their contracts and reducing their workload and financial dependence (Plomp & El Markhous, 2015). Finally, strategic HR policies could be installed that specifically advance the interests of employees, ensuring that HR managers can act as 'guardians of employee wellbeing' (Renwick, 2003a) next to being 'consultants on the rules for line managers'. Hence, several options seem to exist to include a support for employees or a neutral third party in return-to-work processes in the Netherlands.

Nederlandse samenvatting

Sinds de jaren 1990 is er in de verzorgingsstaten van Europese landen een nieuw idee ontstaan van gepast gedrag bij ziekteverzuim. Waar het voorheen vanzelfsprekend was om 'uit te zieken' alvorens terug aan het werk te gaan (en gedurende deze periode een uitkering te ontvangen), is de huidige veronderstelling dat werk en ziekte elkaar niet langer uitsluiten, en dat werk zelfs een positief effect kan hebben op de re-integratie. Een zieke werknemer dient dus, zodra dat mogelijk is, weer (gedeeltelijk) aan het werk te gaan (zij het met aangepaste werktaken of -uren). Het gevolg hiervan is dat niet langer wordt gekeken naar de functie*beperkingen* van de werknemer, maar naar diens resterende werk*capaciteit* (Hetzler, 2009). Deze nieuwe denkwijze over gepast gedrag bij ziekteverzuim vormt het 'activeringsparadigma' en past in het streven van overheden om de arbeidsmarktparticipatie te beschermen en te verhogen, om zodoende de economische onafhankelijkheid van individuen alsmede het voortbestaan van de verzorgingsstaat veilig te stellen (Bonvin, 2008; Eichhorst et al., 2008; Weishaupt, 2011).

Alhoewel het activeringsparadigma tegenwoordig een geaccepteerd discours is op het politieke macroniveau (Bothfeld & Betzelt, 2011; Eichhorst et al., 2008; Weishaupt, 2011), is er in de literatuur nog weinig bekend over hoe organisaties en hun medewerkers dit paradigma daadwerkelijk vertalen in ziekteverzuimmanagement (OECD, 2010; Seing et al., 2014; Tjulin et al., 2010). Dat is opvallend, omdat werkgevers door de invoering van het activeringsparadigma een grotere rol hebben gekregen om middels aanpassingen van werktaken of -uren te zorgen dat zieke werknemers kunnen terugkeren naar hun werk voordat zij volledig hersteld zijn (zie bijvoorbeeld OECD, 2010, 2015). Gezien deze tekortkoming in de literatuur is het doel van mijn proefschrift inzicht te verschaffen in de manier waarop het activeringsparadigma op het gebied van langdurig ziekteverzuim (verzuim van minstens zes weken) gestalte krijgt binnen organisaties. Ik noem dit de 'microfundamenten' van het activeringsparadigma: de processen binnen organisaties waardoor macro-ideeën, zoals het activeringsparadigma, opgepakt worden in lokale praktijken (Powell & Colyvas, 2008, p. 278; Thornton & Ocasio, 2008). De hoofdvraag van mijn proefschrift is: *Wat zijn de microfundamenten van het activeringsparadigma in het ziekteverzuimmanagement van organisaties (ziekenhuizen) in Nederland en Denemarken?*

Deze vraag wordt beantwoord aan de hand van vier subvragen, die in de afzonderlijke hoofdstukken behandeld worden:

1 Hoe is het activeringsparadigma vormgegeven in het nationale ziekteverzuimbeleid in Nederland, Denemarken (en Ierland), in termen van onderliggende ideeën en bestuurssystemen? (hoofdstuk 2)

2 Hoe wordt het activeringsparadigma vertaald in het ziekteverzuimbeleid van organisaties en in het dagelijkse management van ziekteverzuim? (hoofdstuk 3)

3 Wat is de rol van sociale interacties in de vertaling van het activeringsparadigma in lokale ziekteverzuimpraktijken? (hoofdstuk 4)

4 Verschillen re-integratie-ervaringen van de diverse betrokkenen bij fysieke en psychische cases en, zo ja, wat zijn de gevolgen van deze verschillen voor het re-integratieproces in beide cases? (hoofdstuk 5)

Om deze vragen te onderzoeken heb ik gebruik gemaakt van de 'institutionele theorie', die tot doel heeft te verklaren hoe maatschappelijke verwachtingen van gepast gedrag het handelen van organisaties en individuen beïnvloeden (Dacin, 1997; Scott, 2008). Deze verwachtingen bestaan uit regels en wetgeving, normen en overtuigingen, en culturele voorschriften of 'institutionele logica's': expliciete en impliciete regels van gepaste acties en interacties, die behoren bij een bepaalde 'institutionele orde', zoals de staat, religie, markt, familie en professies (Pache & Santos, 2010; Thornton & Ocasio, 1999). Het activeringsparadigma kan gezien worden als zo'n institutionele logica, zoals ik in hoofdstuk 2 laat zien.

In mijn proefschrift heb ik gekozen om een specifieke benadering van de institutionele theorie toe te passen – het 'Scandinavisch institutionalisme' (Czarniawska & Sevón, 1996, 2003) en, in het bijzonder, de 'translatiebenadering' (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996). Deze invalshoek biedt betere mogelijkheden om de vertaalprocessen van institutionele logica's binnen organisaties te onderzoeken dan de macro-georiënteerde institutionele theorie. 'Vertaling' wordt hierbij gedefinieerd als de "min of meer bewuste verandering van praktijken en/of ideeën als verschillende actoren deze praktijken of ideeën proberen te implementeren in hun eigen context" (Røvik, 2011, p. 642; eigen vertaling). Het doel van mijn proefschrift is om verder bij te dragen aan deze benadering door expliciet te kijken naar vertaalprocessen op het microniveau, dat wil zeggen, naar de acties en interacties van individuen. Dit heb ik bijvoorbeeld gedaan door de translatiebenadering te combineren met de 'sociale uitwisselingstheorie' (Blau, 1964), die gedrag op het werk probeert te verklaren door expliciet te kijken naar interacties in organisaties (Cropanzano & Mitchell, 2005; Di Domenico et al., 2009).

Onderzoekscontext

Mijn onderzoek is uitgevoerd in Nederland, Denemarken en (aanvankelijk) in Ierland.[8] De keuze voor deze landen is gebaseerd op hun vergelijkbare verzuimcijfers, en daarmee de gelijke noodzaak om het beroep op uitkeringen voor ziekte (en arbeidsongeschiktheid) te verminderen (OECD, 2008). Daarbij leidde hun reputatie als 'werkgelegenheidswonderen' in de aanpak van werkloosheid (Auer, 2002; Schwartz & Becker, 2005; Torfing, 1999) tot de veronderstelling dat deze drie landen het activeringsparadigma ook hebben geïmplementeerd op het gebied van ziekteverzuim. Een andere reden voor de keuze voor Nederland, Denemarken en Ierland is de verschillende verantwoordelijkheidsverdeling tussen de overheid en werkgevers in het nationale ziekteverzuimbeleid: waar het Nederlandse beleid vooral de (financiële) rol van werkgevers in de aanpak van verzuim benadrukt, ligt de nadruk in het Ierse beleid geheel op de rol van de centrale overheid. Denemarken neemt een middenpositie in: lokale gemeentes zijn hoofdverantwoordelijk, maar werkgevers krijgen een steeds grotere rol. Het is interessant om te bestuderen of deze verschillen leiden tot een andere ziekteverzuimaanpak binnen organisaties.

Daarnaast richt mijn onderzoek zich specifiek op de zorgsector, omdat het management van ziekteverzuim binnen deze sector urgent is, en daarmee een relevante onderzoekscontext biedt. De zorgsector heeft bijvoorbeeld over het algemeen te kampen met hogere verzuimcijfers dan andere sectoren (in 2013 was het gemiddelde verzuimcijfer 3,9 procent in Nederland en 3,8 procent in Denemarken, ten opzichte van respectievelijk 4,8 en 6,1 procent in de gezondheidszorg in beide landen; Statistics Netherlands, 2015a; Statistics Denmark, 2015b). Daarbij dreigt er een tekort aan personeel in de zorg, wat versterkt wordt door de vergrijzende (beroeps) bevolking (Buchan & Aiken, 2008). Het is dus zeer belangrijk voor zorgorganisaties om hun medewerkers te behouden, en te voorkomen dat zij uitvallen wegens ziekte. Binnen de gezondheidszorg richt mijn onderzoek zich op ziekenhuizen (twee in elk land), omdat deze organisaties internationaal goed vergelijkbaar en groot genoeg zijn om voldoende verzuimcases te bestuderen zonder daarbij de anonimiteit en privacy van individuele deelnemers te schenden.

De onderzoeksdata zijn in twee studies verzameld. De eerste studie is een meervoudige case studie op nationaal niveau, waarin het ziekteverzuimbeleid van Nederland, Denemarken en Ierland onderzocht is door middel van een literatuurstudie en 18 interviews met experts op het gebied van ziekteverzuim, re-integratie,

8 Zoals uit hoofdstuk 2 blijkt, is het activeringsparadigma nog niet geïmplementeerd in het Ierse ziekteverzuimbeleid en biedt Ierland daarom uiteindelijk geen geschikte context voor het bestuderen van de microfundamenten van dit paradigma. Daarom is besloten om dit land uit te sluiten van verder onderzoek naar het ziekteverzuimmanagement binnen organisaties.

arbeidsomstandigheden of sociale zekerheid in het algemeen (te weten: overheidsfunctionarissen, vertegenwoordigers van werkgeversorganisaties en vakbonden, en onderzoekers). Deze studie staat centraal in hoofdstuk 2. De tweede studie is een meervoudige case studie naar het ziekteverzuimmanagement binnen twee Nederlandse en twee Deense ziekenhuizen. Hierbij is het ziekteverzuimbeleid van de ziekenhuizen onderzocht, en zijn interviews gehouden met de betrokkenen in 21 langdurige verzuimcases (61 interviews in totaal, met zieke medewerkers, managers en – indien betrokken – Human Resource (HR) managers, vakbondsvertegenwoordigers, bedrijfsartsen en andere professionals rondom arbeid en gezondheid). De hoofdstukken 3 tot en met 5 zijn gebaseerd op deze studie.

Bevindingen

Hoofdstuk 2 verschaft inzicht in hoe het activeringsparadigma vorm heeft gekregen in het *nationale* ziekteverzuimbeleid in Nederland, Denemarken en Ierland, als de noodzakelijke eerste stap om de microfundamenten van dit paradigma te begrijpen. Het activeringsparadigma wordt hier bezien als een institutionele logica die bestaat uit (1) onderliggende ideeën over het probleem van ziekteverzuim en over hoe en door wie dit probleem moet worden opgelost, en (2) een bestuurssysteem bestaande uit een verantwoordelijkheidsverdeling, een beschrijving van rollen en taken, en een keuze voor regulatieve instrumenten. Alhoewel Nederland en Denemarken de onderliggende ideeën van het activeringsparadigma hebben overgenomen in hun ziekteverzuimbeleid, heeft Ierland dat (nog) niet gedaan (waardoor besloten is dit land uit te sluiten van mijn onderzoek, zie voetnoot). Ondanks hun overeenkomsten in onderliggende ideeën, blijken het Nederlandse en Deense beleid te verschillen in hun bestuurssystemen: terwijl Nederlandse werkgevers zowel de financiële als de re-integratieverantwoordelijkheid dragen gedurende twee jaar (zonder de mogelijkheid tot ontslag en met gedetailleerde wetgeving en sancties), zijn Deense werkgevers financieel verantwoordelijk voor 30 dagen en hebben zij een beperkte re-integratieverantwoordelijkheid (met de mogelijkheid tot ontslag en zonder sancties), aangezien gemeentes in Denemarken hoofdverantwoordelijk zijn. Deze verschillende bestuurssystemen zouden kunnen leiden tot verschillende ziekteverzuimpraktijken, wat in de rest van de hoofdstukken onderzocht is en vooral in hoofdstuk 5 en 6 expliciet behandeld is.

De hoofdstukken 3, 4 en 5 zoomen in op het meso (organisatie-) en microniveau en laten zien dat het activeringsparadigma vertaald kan worden als een focus op het welzijn van de medewerker of op kostenreductie, twee interpretaties die niet perse verenigbaar zijn. Om met deze situatie van complexiteit om te gaan, blijkt uit **hoofdstuk 3** dat individuele actoren (exclusief werknemers) in de twee Nederlandse

en Deense ziekenhuizen het activeringsparadigma vertalen door vooral de voor hen meest voordelige elementen over te nemen. Ik noem dit het 'selectief koppelen' van het activeringsparadigma aan lokale ziekteverzuimpraktijken, oftewel: 'de krenten uit de pap halen'. Dit houdt in dat de nadruk van het activeringsparadigma op een vroege re-integratie (dat wil zeggen voordat volledig herstel is opgetreden), in veel gevallen gebruikt wordt om zieke medewerkers zo *snel* mogelijk te laten terugkeren, zelfs als dat volgens de werknemer niet mogelijk is. Deze focus op een snelle re-integratie lijkt te ontstaan doordat ziekte losgekoppeld wordt van de nood tot verzuim in het ziekteverzuimbeleid (bijvoorbeeld in de slogan 'ziekte overkomt je, verzuim is een keuze'), hetgeen het voor individuele betrokkenen mogelijk maakt om werknemers onder druk te zetten om snel terug te keren. Met andere woorden, 'zo *snel* mogelijk' re-integreren blijkt de voorkeur te hebben boven 'zo snel *mogelijk'* terugkeren naar werk, waarbij rekening gehouden wordt met de belangen van de werknemer. Hierdoor lijkt het activeringsparadigma op zo'n manier vertaald te worden dat het voornamelijk overeenkomt met de focus op kostenbesparing.

Hoofdstuk 4 en 5 nuanceren deze conclusie: of het activeringsparadigma vertaald wordt als een focus op het welzijn van de medewerker of op kostenreductie blijkt afhankelijk van de managers' positieve of negatieve perceptie van de sociale interactie met hun werknemers in het heden en het verleden (hoofdstuk 4), alsmede van de oorzaak van de ziekte (fysiek of psychisch) en de verwachte verzuimduur (hoofdstuk 5). Door de vertaling van het activeringsparadigma te bekijken vanuit het 'sociale uitwisselingsperspectief', laat **hoofdstuk 4** zien dat de nadruk op een snelle terugkeer afhangt van de beoordeling die managers geven aan hun sociale interactie met de zieke werknemer. Deze beoordelingen blijken gebaseerd op één of meer van de volgende criteria: de waarde van de zieke medewerker voor de afdeling (loyaliteit), de lengte van het dienstverband, de verzuimfrequentie (alle drie kenmerken van het verleden), de actieve houding van de zieke werknemer om terug te keren naar het werk en diens openheid over medische (on)mogelijkheden in relatie tot werk (kenmerken van het heden). De nadruk op een snelle re-integratie bestaat dan vooral voor zieke medewerkers met een negatieve beoordeling van hun manager: in deze cases worden het activeringsparadigma en de bijbehorende regels strikt vertaald, zonder daarbij in eerste instantie naar de belangen van de werknemer te kijken. Hier verloopt het re-integratieproces problematisch, omdat er conflicten ontstaan tussen managers en werknemers over wanneer en hoe snel de werknemer moet terugkeren. Medewerkers met een positieve beoordeling krijgen daarentegen meer tijd en ruimte om terug te keren naar het werk, door een flexibele vertaling van het activeringsparadigma. Daarbij moet echter opgemerkt worden dat deze werknemers al een actieve houding vertonen om snel terug te keren naar het werk.

Hoofdstuk 5 vergelijkt de re-integratie-ervaringen van individuele betrokkenen tussen fysieke en psychische cases. Dit hoofdstuk toont aan hoe de focus op een

snelle re-integratie vooral optreedt bij werknemers die verzuimen met psychische klachten; bij fysiek zieke werknemers is dit alleen het geval als hun re-integratie langer duurt dan verwacht. In de Nederlandse ziekenhuizen komt deze druk vooral tot uiting tijdens het bepalen van de resterende werkcapaciteit door de bedrijfsarts bij psychische cases, die in zijn beoordeling (volgens de werknemer) te snel beslist dat een werknemer kan re-integreren, zonder daarbij diens klachten te erkennen. In de Deense ziekenhuizen lijkt de focus op een snelle terugkeer bij zowel psychische als fysieke klachten te ontstaan bij het ontbreken van een re-integratieplan, het afwijken van de gemaakte plannen of als dit plan niet is afgestemd op de behoeften van de medewerker. Ook hier ontstaan conflicten tussen de werknemer en de manager over wanneer en hoe snel de werknemer moet re-integreren. Van beide landen kan geleerd worden: de Deense cases laten zien dat de focus op een snelle terugkeer voorkomen kan worden door een vertegenwoordiger van de vakbond of de gemeente te betrekken als een steun voor de zieke werknemer, terwijl uit de Nederlandse cases geconcludeerd kan worden dat het re-integratieplan – los van de aard van de ziekte – belangrijk is als een leidraad voor de werknemer, mits dit plan rekening houdt met de behoeften en mogelijkheden van de werknemer. Ondanks het bestaan van verschillende percepties over fysieke en psychische klachten, toont dit hoofdstuk de relevantie van een gelijkwaardige dialoog over resterende werkcapaciteit alsmede het belang van een re-integratieplan, ongeacht de aard van de ziekte.

Samenvattend laat mijn proefschrift zien dat de *snelheid* van re-integreren centraal staat in de vertaling van het activeringsparadigma binnen organisaties, maar ook dat het management van ziekteverzuim een subjectieve praktijk is, waarbij percepties van andermans gedrag (in dit geval van de zieke werknemer) en verwachtingen over (het verloop van) ziektes beïnvloeden hoe omgegaan wordt met verzuim. In tegenstelling tot de assumptie dat de verschillen tussen Nederland en Denemarken (in termen van rollen en verantwoordelijkheden van werkgevers) zouden leiden tot een andere manier van ziekteverzuimmanagement, bleken mijn bevindingen juist erg vergelijkbaar tussen beide landen. Dit kan betekenen dat lokale situaties meer impact hebben dan macro-ideeën (zoals het activeringsparadigma), maar ook dat Nederland en Denemarken wellicht niet zo verschillend zijn: beide landen zijn “kleinere, hoogontwikkelde Noordwest-Europese landen met een vergelijkbare cultuur van tolerantie en flexibiliteit en met een sterke toewijding aan de sociale rechten van burgers” (Van Oorschot & Abrahamson, 2003, p. 289, eigen vertaling). De overeenkomsten in mijn bevindingen kunnen er echter ook op wijzen dat de strenge, gedetailleerde wetgeving in Nederland (inclusief sancties) en de normatieve wetgeving in Denemarken (zonder sancties, maar inclusief morele overreding door campagnes) hetzelfde effect hebben (zie bijvoorbeeld Vasudeva, 2013).

Theoretische bijdragen

Mijn proefschrift draagt op drie manieren bij aan de (Scandinavische) institutionele theorie en de translatiebenadering. Allereerst bevestigt mijn onderzoek het belang van een multi-niveau benadering binnen de institutionele theorie, en in het bijzonder in het bestuderen van de microfundamenten van institutionele logica's (Battilana, 2006; Reay et al., 2013; Van Gestel & Hillebrand, 2011). Op elk van de niveaus (macro, meso, micro) is duidelijk geworden dat logica's niet op zichzelf bestaan, maar "dat ze alleen betekenis krijgen indien zij uitgedragen worden in de praktijk" (Lindberg, 2014, p. 496, eigen vertaling). De toepassing van de translatiebenadering in mijn studie laat echter zien dat tijdens de vertaling van een bepaalde logica, interpretaties en acties op microniveau in strijd kunnen zijn met veronderstellingen en intenties op macroniveau (bijvoorbeeld door 'selectief koppelen'). Mijn onderzoek wijst hiermee op het belang van het onderzoeken van (inter)acties op het individuele niveau om de microfundamenten van institutionele logica's te begrijpen, en laat zien hoe de translatiebenadering daarvoor een geschikte invalshoek biedt.

Een tweede bijdrage van mijn proefschrift relateert aan de definitie van 'institutionele complexiteit', als de situatie waarin de voorschriften van meerdere institutionele ordes en hun logica's met elkaar botsen (Greenwood et al., 2011). Mijn onderzoek laat zien dat institutionele complexiteit niet alleen hoeft te bestaan bij twee of meer institutionele logica's, maar dat dit ook kan voorkomen binnen één logica, als die op meerdere manieren geïnterpreteerd kan worden en deze interpretaties met elkaar botsen. Zo blijkt het activeringsparadigma interpreteerbaar te zijn als een focus op het welzijn van de medewerker en als een focus op kostenbesparing. Deze foci bleken niet perse verenigbaar, omdat beide interpretaties ander gedrag voorschrijven: investeren (in het welzijn van de medewerker) versus besparen. Deze situatie van 'intra-logica complexiteit' kan leiden tot verschillende lokale praktijken. Alhoewel er wel oproepen zijn geweest om de definitie van 'onverenigbaarheid' aan te scherpen (Greenwood et al., 2011; Smets & Jarzabkowski, 2013) alsook van 'institutionele' logica's (R.E. Meyer & Höllerer, 2014), is het bestaan van complexiteit binnen logica's nog niet eerder beschreven in de literatuur.

Ten slotte heeft mijn onderzoek inzicht gegeven in een tot nu toe grijs gebied binnen de institutionele theorie: *hoe* en *waarom* individuele actoren (in plaats van organisaties als geheel) reageren op institutionele logica's (McPherson & Sauder, 2013; Pache & Santos, 2013a; Thornton et al., 2012). Mijn proefschrift laat zien dat individuele actoren kunnen reageren op institutionele logica's door het 'selectief koppelen' van deze logica's aan hun dagelijkse praktijken, door alleen de meest voordelige elementen te gebruiken ('de krenten uit de pap halen', zoals de focus van het activeringsparadigma op het terugkeren naar werk voordat volledig herstel is opgetreden). Op deze manier implementeren individuele actoren de voorschriften van

gepast gedrag (in tegenstelling tot de situatie bij 'ontkoppelen', J.W. Meyer & Rowan, 1977), maar zodanig dat zij daarmee ook andere (organisatie)belangen dienen, zoals kostenbesparing. Daarnaast heeft mijn onderzoek inzicht verschaft in de motivaties van individuele actoren om de voorschriften van een logica te volgen: hoewel de veronderstelling binnen de institutionele theorie is dat mensen gemotiveerd worden door hun behoefte om zich gepast te gedragen (March & Olsen, 2006), laat ik zien dat dit geldt als er een 'norm van wederkerigheid' bestaat, die is gebaseerd op het gedrag van de ander (zoals managers die met hun gedrag reageren op hun perceptie van het gedrag van zieke werknemers). Met andere woorden: alleen als de één zich gepast gedraagt, zal de ander dit ook doen. Dit noem ik een 'quid pro quo' mechanisme.

Maatschappelijke bijdragen

Implicaties voor beleid

Ondanks de daling van de landelijke verzuimcijfers (in Nederland bijvoorbeeld van 4,7 procent in 1996, naar een stabiele 4,2 procent in de periode 2004-2011, en naar 3,8 procent in 2014; Statistics Netherlands, 2015a), zijn er nog steeds veel zieke werknemers die de arbeidsmarkt verlaten op een arbeidsongeschiktheidsuitkering (in Nederland zijn dat 38.000 mensen per jaar; UWV, 2015). Dit kan wijzen op de aanwezigheid van het 'gezonde werknemer effect', waarbij de gezonde werknemers aan het werk blijven terwijl de ernstig zieken, die niet 'zo *snel* mogelijk' terug kunnen keren, de arbeidsmarkt verlaten. Zo bezien lijkt het huidige beleid in zowel Nederland als Denemarken – dat in mijn organisaties geïnterpreteerd wordt als een focus op de snelheid van re-integreren, zonder daarbij altijd rekening te houden met de behoeften en mogelijkheden van de werknemer – niet te leiden tot een inclusieve arbeidsmarkt voor iedereen.

Voortbouwend op de bevindingen van mijn onderzoek, lijkt het aannemelijk dat de re-integratie van zieke werknemers binnen organisaties altijd gefocust zal zijn op 'snelheid' als de financiële lasten gedragen dienen te worden door werkgevers, die tegelijkertijd geconfronteerd worden met andere (bedrijfs)belangen. De vergelijkbaarheid van mijn bevindingen tussen Nederland en Denemarken laat zien dat het bij deze financiële lasten niet alleen gaat om de wettelijke loondoorbetaling bij ziekte, maar ook om de indirecte verzuimkosten (zoals de kosten van productiviteitsverlies, vervangend personeel, re-integratieondersteuning). Het lijkt dus aan te raden om de kosten van verzuim voor werkgevers te verlagen, alhoewel een zekere mate van financiële prikkeling nodig is om werkgevers aan te zetten tot actie op het gebied van preventie en re-integratie (zie hoofdstuk 5; Cuelenaere & Veerman, 2011).

Een geschikte verantwoordelijkheidsverdeling bij ziekte lijkt dus te liggen

tussen de Nederlandse en Deense situatie in, en impliceert een verlaging van de financiële verantwoordelijkheid voor werkgevers in Nederland, met behoud van hun verantwoordelijkheid voor het re-integratieproces, en een vergroting van vooral de re-integratieverantwoordelijkheid voor werkgevers in Denemarken. Door wederom naar andere landen te kijken, kan een mogelijke verantwoordelijkheidsverdeling wellicht ook letterlijk tussen beide landen in gevonden worden. Bij ziekteverzuim blijken werkgevers in Duitsland namelijk gedurende zes weken financieel verantwoordelijk te zijn (langer dan in Denemarken, maar korter dan in Nederland), terwijl ze de verplichting hebben om zieke werknemers te re-integreren gedurende anderhalf jaar. De kosten hiervoor worden echter gedragen door zorgverzekeraars (de 'Krankenkassen') en het proces wordt begeleid door een ervaren 'Fallmanager' (Verwer et al., 2013, 2014). Gezien de lagere ziekteverzuim- en arbeidsongeschiktheidscijfers van Duitsland ten opzichte van Nederland (Verwer et al., 2014), is het voor toekomstig onderzoek interessant om de re-integratieprocessen binnen Duitse organisaties te bestuderen om te bezien of het Duitse beleid daadwerkelijk een goede oplossing biedt voor Nederland en Denemarken.

Implicaties voor organisaties

Mijn proefschrift wijst op het belang van een andere kijk op ziekteverzuimmanagement dan de focus op ziekteverzuimcijfers en een zo *snel* mogelijke terugkeer. Het is niet ondenkbaar dat de conflicten binnen sommige cases in mijn studie de duurzaamheid van de re-integratie of van de arbeidsrelatie aantasten, hetgeen mogelijk resulteert in verloop. Zo hebben Arends et al. (2014) laten zien dat conflicten tussen leidinggevenden en werknemers die verzuimen vanwege psychische klachten, de kans op terugkerend verzuim vergroten. De nadruk op het beheersen van verzuimcijfers kan er bovendien toe leiden dat werknemers ziek doorwerken omdat ze niet meer durven te verzuimen ('presenteïsme'; Taylor et al., 2010). Zowel verloop als presenteïsme blijken de productiviteit van een organisatie te verlagen en de dienstverlening te verslechteren (Johns, 2010; Park & Shaw, 2013). Bovendien leidt een dergelijke aanpak niet tot de preventie van gezondheidsproblemen (Taylor et al., 2010; Van Gestel et al., 2015), ondanks het toenemende belang van preventie door de vergrijzende (beroeps)bevolking en een veranderende leefstijl en werkomgeving. De verwachte toename in chronische ziekten (zoals hart- en vaatziekten, kanker en diabetes), zullen ertoe leiden dat steeds meer mensen de zorg voor hun ziekte moeten combineren met hun werk (Van Gestel et al., 2013). Een eenzijdige focus op een *snelle* terugkeer, zonder daarbij de (werk- en gezondheidsgerelateerde) oorzaken van verzuim aan te pakken, kan dus op de lange termijn een kostbare strategie zijn.

Mijn onderzoek biedt twee aanbevelingen om het management van ziekteverzuim te verbeteren. Een eerste aanbeveling betreft het onder de aandacht brengen van

percepties en verwachtingen in ziekteverzuimmanagement, om zo mogelijke conflicten tussen werkgevers en werknemers te voorkomen die het re-integratieproces kunnen vertragen. Het is hierbij van belang om de betrokkenen, en vooral managers, bewust te maken van hun percepties van werknemers en de gevolgen van deze percepties voor hun benadering van verzuim. Deze bewustwording kan gerealiseerd worden door middel van 'focus groepen' (Ivanoff & Hultberg, 2006), waarbij de in hoofdstuk 4 gevonden percepties die managers hadden van hun zieke werknemers kunnen dienen als uitgangspunt voor discussie (loyaliteit, lengte van het dienstverband, ziekteverzuimfrequentie, actieve houding om te re-integreren, openheid over (on) mogelijkheden in relatie tot werk). Vervolgens kunnen de betrokkenen gestimuleerd worden om meer objectief te handelen bij ziekteverzuim (bijvoorbeeld met betrekking tot managers: los van het gedrag van werknemers in het verleden) of om beter te communiceren over verwachtingen ten aanzien van werknemers (zoals het vertonen van een actieve houding en openheid) en van managers (zoals het erkennen van de ziekte, rekening houden met de belangen van de werknemer). Hierbij zijn goede communicatievaardigheden onontbeerlijk (zie hoofdstuk 5).

Een tweede aanbeveling betreft de decentralisatie van verantwoordelijkheden bij ziekteverzuim van HR naar lijnmanagers. Ondanks de voordelen van lijnmanagers als case managers (hun grotere bekendheid met de werknemer, het werk en de werkplek), hebben zij te maken met belangen die moeilijk verenigbaar lijken te zijn: de zorg voor de werknemer en die voor de organisatie. Mijn studie heeft laten zien dat deze tegenstrijdige belangen leiden tot een focus op een zo *snel* mogelijke re-integratie, wat voornamelijk ten gunste komt van organisaties (op korte termijn). Een oplossing voor dit dilemma zou kunnen zijn om een support voor de werknemer aan te wijzen, of om te zoeken naar een neutrale derde partij. Hierbij kan in Denemarken besloten worden om de vakbonds- of gemeentevertegenwoordiger bij aanvang van *alle* (langdurige) ziekteverzuimgevallen in te schakelen (zie hoofdstuk 5). In Nederland zijn er verschillende actoren die een ondersteunende of neutrale rol zouden kunnen spelen, mits de huidige invulling van hun rollen veranderd of aangevuld wordt. Zo zouden vakbonden, ondernemingsraden en gemeentes, die op dit moment werknemers vertegenwoordigen op het nationale/sectorale niveau of op het organisatieniveau, of die nog geen wettelijke rol spelen bij ziekteverzuim, een (grotere) rol kunnen krijgen in het re-integratieproces van individuele medewerkers. Een andere optie is om de ondersteunende of onafhankelijke positie van bedrijfsartsen te bevorderen, door bijvoorbeeld hun contracten uit te breiden, hun werkdruk te verlagen en hun financiële afhankelijkheid te verminderen (Plomp & El Markhous, 2015). Ten slotte kunnen organisaties strategisch HR beleid invoeren dat specifiek gericht is op het bevorderen van de belangen van werknemers (Renwick, 2003a), zodat HR managers voor zowel werknemers als werkgevers een rol kunnen spelen.

It always seems impossible
until it's done

Nelson Mandela

Dankwoord

Om niet te verdrinken in alle literatuur en onderzoeksdata, heb ik tijdens mijn promotietraject figuurlijk én letterlijk beter (moeten) leren zwemmen. Maar gelukkig heb ik dat gedurende de afgelopen jaren niet alleen hoeven doen!

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voor jullie interesse en morele steun tijdens mijn promotietraject. Werken in onze kamer voelde als een warm bad en ik weet zeker dat het een stuk moeilijker (zo niet onmogelijk) was geweest om boven water te blijven als jullie er niet waren geweest. Nog een speciaal woord van dank aan Laura B. en Laura V. als mijn paranimfen. Te weten dat jullie achter mij staan, is een heel fijne gedachte. Ik ben trots dat ik op deze manier het bestaan van "de Laura's" officieel kan vastleggen.

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About the author

Emmie Vossen was born on June 9th 1985 in Kerkrade, the Netherlands. She completed the Gymnasium (pre-university education) at College Rolduc, Kerkrade, in 2003. From 2003 to 2006, Emmie studied Psychology at Tilburg University, for which she received a Bachelor's degree in 2006. After that, she completed two Masters at Radboud University (both cum laude): Work and Organizational Psychology at the faculty of Social Sciences (2008) and Strategic Human Resource Management (HRM) at the Nijmegen School of Management (2010). For her first thesis, Emmie did a six-month HRM internship and research at the Radboud University Medical Center. Emmie's second thesis was a preview of her current dissertation, as it was about sickness absence management in relation to national sickness absence policies in the Netherlands and Denmark, but focused on HR managers within professional service firms.

After finishing her studies, Emmie worked as a statistical researcher at the Statistics Netherlands (CBS) for one year, after which she started her PhD project at the department of Business Administration, section Strategic HRM, of Radboud University. During this project, Emmie visited and participated in several conferences: the *Dutch HRM Network Conference*, Groningen (November 2011), the *Organizational Behavior in Healthcare Conference*, Dublin (April 2012), the *European Group for Organizational Studies Conference*, Helsinki (July 2012), the *International Labor and Employment Relations Association Conference*, Amsterdam (June 2013), the *Organizational Behavior in Healthcare Conference*, Copenhagen (April 2014), the *European Group for Organizational Studies Conference*, Rotterdam (July 2014), and the *European Network for Social Policy Analysis Conference*, Oslo (September 2014). During her PhD project, Emmie was co-author of a book on the future of social security in the Netherlands (*"Toekomst van de Sociale Zekerheid: Over Provisie, Preventie en Participatie"*, written by Nicolette van Gestel, Emmie Vossen, Shirley Oomens, and David Hollanders), for which she wrote three chapters on sickness absence and disability. She also participated in the supervision of Master's theses. Since May 2016, Emmie is employed as a Work and Organization Consultant at HumanCapitalCare, an occupational health service.